VOLUME SIXTEEN ▪ NUMBER FOUR ▪ WINTER 1995

HUMAN DEVELOPMENT

The Jesuit Educational Center for Human Development

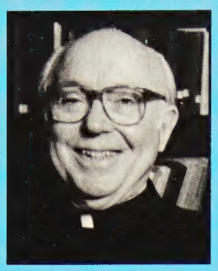
A Leader's Ministry

Imaginative Theological Reflection

Understanding the Multiple Personality

Techniques for Religious Formation

Addictions of the Clergy



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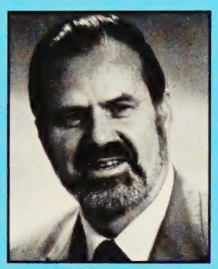

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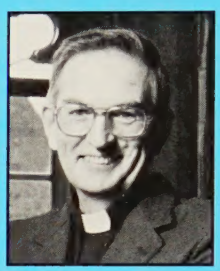

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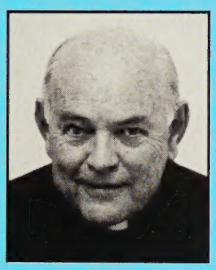

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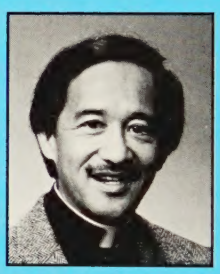

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INFORMATION FOR AUTHORS

The editors are pleased to consider for publication articles relating to the ongoing work of those involved in helping other people through religious leadership and formation, spiritual direction, and counseling.

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EDITOR'S PAGE

THE SURPRISES AND PROMISES OF CHRISTMAS

It's natural to have mixed feelings about Christmas. The same is true when facing the start of a new year. We have all experienced both of these events so many times that it would be impossible not to react to their arrival with a blend of sentiments ranging all the way from joy and excitement to sadness and heartache. Such emotions are attached to our memories of marvelous surprises and painful absences that deeply touched our souls during holiday seasons in the past, all the way back to early childhood. It is our life history that gladdens our hearts or darkens them when we hear the strains of "Silent Night" or the singing of "Auld Lang Syne."

Christmas has always been an occasion for emotional surprises. At Bethlehem, Mary and Joseph expected to find a room at the inn, but instead found themselves laying their swaddling-clothed Child in a manger to rest. Shepherds in the nearby hills were surprised, and at first terrified, by the God-sent angel who announced to them the birth of "a savior . . . Christ the Lord." An added surprise was the "great throng of the heavenly host, praising God and singing: Glory to God in the highest heaven, and peace to all who enjoy God's favor." Then the Holy Family was surprised by the shepherds who came to visit them. In turn, the people of Bethlehem were surprised when the shepherds described to them what they had seen and heard, and what the angel had told them about the Infant in the manger.

Fortunate children feel a similar kind of surprise when they unwrap presents on Christmas morning and discover what Santa has left for them under the ornamented tree. Husbands and wives know the same joyful feeling when they open brightly wrapped gifts that have been thoughtfully chosen to enrich their happiness. An entire family can be surprised and overjoyed when a long-absent member arrives home unexpectedly to join them in celebrating the holidays.

But I'm not sure that surprises bring the fullest measure of joy and happiness. There is something to be said for pleasures that are *anticipated*. Those who look forward to attending a concert, bowl game, or theatrical performance, and who for weeks or months have already had their tickets in hand, usually seem to enjoy the long-awaited event considerably more than people who impulsively decide to go at the last minute. The same thing occurs when people carefully plan a holiday excursion a long time ahead, make their travel reservations early, and then relish their trip in anticipation, not just during the days they are traveling. Somehow, it seems easier to get through a difficult week or season when you know that at the end of it you will be attending, with those you love, a dinner, birthday party, New Year's dance, or some other social event that you are certain you will enjoy. Sometimes, just knowing in advance that you will be opening a much-desired gift on Christmas can add even more pleasure to the whole season than would be derived from receiving the same gift as a total surprise.

So, as we look forward to this year's Christmas and the upcoming new year, which are bound to bring a variety of surprises (welcome ones, we hope), it's wonderful to know that in our future there are also things that we can confidently anticipate receiving and enjoying. These are the gifts that Christmas was designed by God to promise, and we can brighten and warm all our days by keeping them in mind.

Bethlehem is God's guarantee that we are *saved* and that places are reserved in Heaven for us and all those we love. There we will be joining shepherds and angels and the Holy Family in a life of peace and happiness without end. The carols, holly, and tinsel should remind us that Love was born for us on Christmas and that—because of the Christ Child—we are God's cherished ones now and forever.

James J. Gill, S.J., M.D.
Editor-in-Chief

The editors, editorial board, and staff of HUMAN DEVELOPMENT, *along with the administrators, faculty, and staff of the Christian Institute for the Study of Human Sexuality, send our heartfelt Christmas greetings to all our readers, writers, students, and benefactors. We thank every one of you for the excitement, warmth, and joy you contribute to our lives. May God's best blessings come to you during the Christmas season and throughout the entire new year.*

A Leader's Ministry

Ann Margaret O'Hara, S.P.

In my years of working with leadership of women religious, I have found that the challenges of ministry with congregation members evoke deep emotional reactions and many questions: How can I deal with the tensions I experience in my personnel ministry within my congregation? How do I, as a leader, invest in the human resources of the congregation—encouraging and inspiring our members to their full potential for the mission—and at the same time address the real therapeutic needs of some members? How do I keep 5 percent of the members from using 90 percent of my time? How can I achieve balance in the face of unrealistic and conflicting expectations, both on my part and on the part of my sisters? How do I keep my personal issues from unduly influencing or blocking my ministry with others? Do I even know what those issues are? How can I guard my time and space for reflection and renewal while immersed in the congregation? What is the balance between my personal life and my congregationwide role?

As provincial and general councilor with the Sisters of Providence, I have had the most rewarding and satisfying ministry experiences of my life. It has been exciting to be at the center of this community of women and also with persons on the edges—and it has at times been frustrating and painful. I believe the sources of both the joy and the pain are my high hopes for us and my tendency to push for the possible. Also, the depth of feeling comes from the reality that whatever it is we are about—discernment, policies, procedures—it is more than ministry or pastoral care; it is our life.

Leaders have a personal history with, relationship with, and life commitment to their members. Some of them are close friends. And for a period of time, leaders also have an administrative relationship with their members. This dual relationship, I believe, is integral to the level of tension some experience in congregation ministry.

I offer the following thoughts on maintaining a delicate balance in the face of unrealistic and conflicting expectations for leaders in ministry with their own members. These have been gathered from my eleven years' experience and the invaluable sharing of many religious leaders in my own and other congregations.

UNREALISTIC EXPECTATIONS OF MEMBERS

Leaders have high levels of expertise in all aspects of working with people. Most religious elected to leadership have some background in pastoral ministry, counseling, spiritual companioning, and communications, or natural abilities in these

areas. Their skills and experience facilitate their relationships with members. However, if a leader is experiencing significant stress in relating one-to-one with members, additional training or workshops might be helpful.

Before the leader seeks to gain additional expertise, however, he or she must determine if members' expectations regarding background for leadership are realistic. The leader need not be a clinical psychologist, spiritual director, or health care professional.

What is important is for the leader to identify the resources he or she has and to know when to refer a member to other resource persons. The most important resource the leader has is himself or herself; the leader can use outside resources to enhance and support his or her ministry skills.

For the most authentic relationships, the leader will want to build on personal style, skills, and gifts. After attending too many workshops on dealing with people, I finally realized that there is no one absolutely right approach. There are basic pastoral, healthy, and just principles that can be communicated in a variety of ways. The key to personal ministry is to trust one's self and one's life experience.

The leader can also use resources for his or her own personal integration. The greater the self-knowledge and self-acceptance of the leader, the greater will be his or her empathy and ability to assist others. Some leaders have found it extremely helpful to meet regularly with a consultant, preferably someone with both a psychological and pastoral ministry background. During the consultations, the leader can obtain feedback on ministry approaches, get input on behaviors of others, discuss options for referrals, and deal with his or her own feelings, issues, blocks, and overreactions. This is not only an enlightening process but also a highly supportive one. Others in personnel ministry use a peer-group consultation approach or meet in an informal support group.

Of course, religious leaders can't sustain personnel ministry solely on educational and psychological resources. Dealing with other people's crises and faith questions affects their own faith reflection and prayer. Theological reflection on ministry experiences is essential for integration and even for sanity at times.

Perhaps the greatest expertise the leader really needs is knowing when to refer a member to other resource persons—staff or outside professionals. This is key to maintaining balance in personnel ministry within the congregation. However, the leader need not be a professional diagnostician. Use of consultants in assessing the need for referral is crucial. For example, most counseling centers can provide descriptions of observed behaviors that indicate the need for referral, from minor to major psychological difficulties and chemical dependency. Many leadership teams have available a psychological and/or medical consultant.

Religious leaders have unlimited responsibilities and are constantly accessible. When congregation leaders express feelings of being overwhelmed by personnel ministry, they often speak of expectations of availability for every need of their members. The leader generally is not the spiritual director of each person with whom he or she relates, but the leader certainly raises spiritual issues and suggests spiritual opportunities. The leader does not act as therapist but can raise psychological questions about a person's stress level, encourage developmental growth, and recommend therapy.

The leader does not act as physician or nurse but encourages individuals to seek medical care and develop wellness lifestyles, and sees that appropriate services are provided for members when necessary. He or she does not act as social director or activities coordinator but supports opportunities and initiatives.

The leader is not accessible at all hours of every day and night for regular community discernment and questions. Most busy people have learned that the only way to get their own time is to schedule it in and not to give it away. One way to guard it includes screening calls in the home setting and responding only to real emergencies on personal time. When a chronically needy person calls to rehash an old conversation at the end of a draining day for the leader, a simple and truthful response might be: "I can't talk right now, but you can call me tomorrow afternoon or next week."

I don't believe it is fair, however, to expect visits or phone contacts from members exclusively during "business" hours. Many members are involved in ministries that do not afford time for relaxed or confidential conversation during those hours. When scheduling visits or phone calls with such members for evenings or weekends, it is important to schedule compensatory time off during the week or earlier in the day. Many leaders have found it essential not to live with team members or staff as a way of keeping ministry concerns from invading personal time.

The challenge for leaders is to find reflective time during a varied schedule. Long trips in my car are especially integrating for me. Thus, when a sister suggested that I get a car phone some years ago, I began to hyperventilate.

It is extremely important for the leader to establish boundaries with the chronically needy. They will take 150 percent of the leader's time if he or she lets them. These individuals have very low insight

and a high need for security. Many have patterns of passive dependency or passive aggression. They are often characterized as stubborn, manipulative, isolated, lacking any leisure life, anxious, and afraid to make decisions.

It is important to limit the time spent visiting with chronically needy people ("I have 30 minutes before my meeting"). Acknowledge their feelings but focus on the specific reason for the visit. Help them to realize they belong to someone, somewhere. Learn not to do for them what they can do for themselves. In acknowledging their needs, help them identify how they might be appropriately met (e.g., through staff, the community health coordinator, outside centers, or services available through such organizations as Alcoholics Anonymous). Also, focus on their own resources.

Just as the leader is not accessible for every need of members or at all times, he or she is also not accessible in every setting. Perhaps one of the most frustrating expectations is that leaders are always fair game for any business, whenever and wherever members encounter them: at meals, in the middle of a meeting, during social gatherings. My most astounding experience involved a sister who attempted to raise community business with me at the kiss of peace during liturgy. Another wanted to discuss her ministry discernment during a funeral procession. It is difficult but important to respond to these surprise encounters by discouraging them as they happen.

Often a community member who is experiencing difficulty expects that the leader will be as emotionally available in a group setting as he or she was during an earlier intimate individual visit. The individual may attempt to continue the private conversation in the group context, with the same intensity, expecting the leader's full attention. The leader, on the other hand, needs to be present for a number of members for another purpose and may have responsibilities for the meeting or celebration. The delicate balancing act is to greet the individual with warmth and support while communicating that some future time and another place are better for an in-depth conversation. Depending on that person's insecurity and neediness, he or she may or may not be able to hear and accept these limits. However, the leader must have the confidence to set these boundaries in order to maintain a balance within the entire range of his or her relationships and responsibilities.

Setting appropriate limits may force the leader to reflect on his or her self-perception as a minister. Are there ways in which the leader sees himself or herself as a savior, authority, or problem solver for all needs? Or does the leader support and encourage others in their own decision making, referring them to others as necessary, and discerning with them the decisions they need to make in the context of mission and community guidelines?

If members experience leadership only in times of crisis, this communicates a therapeutic or maintenance model of personnel ministry rather than a developmental or proactive model

The major purpose of personnel ministry is the growth of the members for their own development and for the mission. If members experience leadership accessibility only in times of crisis, this communicates a therapeutic or maintenance model of personnel ministry rather than a developmental or proactive model. Visits with members should focus on supporting them and understanding better the mission of the congregation in its local realities rather than responding to crisis calls.

ATTENTION TO HEALTHY MEMBERS

Planning ways to invest in the healthy, vital members of the congregation gives focus to the leader's interactions with them. Encouraging members in a life-planning process and challenging them to pursue new growth opportunities and new ministries will stir their vitality. If leaders consciously initiate contacts with members to tap their leadership and creativity, their personnel ministry will attain a proportionate balance of working with both the healthy and the needy. Of course, even the healthy are not always moving toward wholeness. However, access to educational programs (e.g., in apostolic spirituality or conflict management), support during transition times (e.g., midlife, periods of grief), and encouragement to obtain counseling as needed minimize stress and maximize learning for community members.

In some cases, a member perceives the leader to be more than the leader. The psychological phenomenon of transference may be occurring. The member's reaction to the leader may be based on feelings about a significant person in the member's past. For instance, an individual may have an authority problem—that is, he or she may be unduly guarded, angry, hostile, or critical of persons in leadership. Leaders may bear the brunt of emotions meant for authoritarian parents or former superiors or supervisors. In such cases, it may be helpful for leaders to acknowledge their feelings about the interaction ("I feel you really are having difficulty trusting me. What do you suggest would be helpful?").

A different emotional response may be experienced by members who received very little healthy parenting or attention while growing up. If a leader relates warmly and responsively with community members, such an individual may feel that the leader is lavishing extraordinary affection and investment upon him or her. Because of the contrast with the individual's early experience, the leader may become a parent figure for that person during the process of healing. While the appropriate relationship between leaders and members is one of mutual responsibility and respect, it is understandable that for a time, persons of impoverished backgrounds will have dependent and/or unrealistic expectations. Because the relationship is distorted, such individuals will overreact to what they perceive as positive or negative interactions. An insignificant comment takes on potential for hurt or communicates "best friend" qualities about the relationship. For example, a sister interpreted the concern and support I expressed during one visit as a sign of a close personal relationship. She inquired at the next visit if I would like to go on vacation with her.

Leaders have the ability and the personal and professional resources to solve their members' problems. Often the community or local group wants leaders to fix others, or individuals want leaders to fix them—make them happy, fix a situation of conflict, fix their world, find them a job. They usually want the fix by changing everything except themselves (e.g., self-image or response to difficulty, situation, behavior). The most seductive expectation that some members nurture is that everyone else wants to and will change so that their conflicts may be resolved. Actually, leaders do not have the ability to change others or the right to take responsibility for their decision making. A leader who attempts to do these things gets blamed for everything.

In situations of group conflict, one of the parameters a leader might set is to refuse to come into the situation until the group members themselves have discussed the problem. A leader may also offer the use of an outside facilitator over a period of time rather than choose to facilitate personally.

In discernment about serious problems in a member's life, it is important for the leader to be present and to listen with care. Some brief goals may be (1) acknowledge the individual's feelings and their validity, and help clarify them; (2) do not necessarily respond to every concern or offer answers; (3) be supportive and empathetic; (4) provide the process for the individual's discernment or decision; (5) provide referral suggestions if other assistance is needed; (6) help the individual to explore options for solving the problem; (7) follow up.

While feeling empathy for the person, who may be hurting or angry, the leader also needs to track what is going on in the interaction. This is particularly difficult when the person is sending the leader conflicting messages. Sometimes the individual wants the leader to be involved in his or her decision-making process. But if that person does not like where the consultation is leading, he or she may opt out, deny facts, accuse the leader of manipulation, or go to another team member for help. The leader needs to address this when it happens ("Do you realize you are giving opposing messages?").

The leader can get caught in the classic triangle. Whoever is approached by a member in a triangle situation should respond, but in almost all cases, he or she should refer the member back to the original discerner ("I know you are discerning this with Sister Mary, so I am passing on your letter to her"). A trap leaders sometimes fall into in these situations is delivering members' messages. This shifts responsibility from the member to the leader.

One of the personalities I find most difficult to deal with is the passive-aggressive person. She is the sister who says one thing and means the opposite, asks for help and resists any suggestions, tells the leader how angry she is while smiling sweetly. One rule of thumb I at least consider in interactions with these individuals is "Do what they say, not what you think they mean."

One of the most startling experiences I had with passive-aggressive behavior occurred with a sister who was hospitalized but not seriously ill. When I phoned her in the hospital after she had been there several days, her first words told me volumes: "Oh, Sister, you have many more important things to do than to visit me in the hospital, and I am going to be released around noon." I assured her that I was concerned and would be stopping by to see her shortly. When I arrived at the hospital, she had already checked herself out early. I went to the convent to meet with her and

gently suggested that she must have been really hurt and angry with me to have left early.

Leaders should always resolve conflicts between the needs of the individual and the needs of the community in favor of the individual. In the balancing act between the individual and the community, it is important for the leader to be in touch with the needs of both. Knowing all the needs usually limits the options and merges the concerns of both sides. The most objective approach in searching for balance is to have in place as many criteria, policies, and procedures for decision making as possible. Of course, it is essential to involve the members in formulating such policies and procedures and to publish them congregationwide.

When it is obvious that an individual's request can't be fully implemented, offer as many options or alternatives as possible or make counterproposals ("You can't study full-time now, but you could begin one class this year and request full-time for next year").

Flexibility is extremely important in policy implementation. A policy is a broad direction statement for decision making. Leaders must know when to make exceptions—for example, to set aside a time line or to go over budget when the need in an individual's life (time off, sabbatical, counseling) is critical.

LEADERS' UNREALISTIC EXPECTATIONS

All members will heal and grow quickly once proper discernment takes place. It is important to have a fairly accurate assessment of a person's ability to change, respond, grow, cooperate, and cope. Leaders also have to be realistic about the rate at which these developments happen. Individuals do not heal on the leader's schedule; they certainly don't die on anyone's schedule. Some insight into a person's ability to change or rate of change may be gleaned from evidence of his or her faith and psychological development.

Individual members may experience difficulties all along the range of behavior and emotions. They may simply be blocked or stuck in a relationship or situation, caught in a rut, or too long underchallenged. An effective discernment process, spiritual companioning, short-term counseling, or therapy may be helpful. Some members may be experiencing a faith or vocation crisis or serious psychological difficulties that will require psychotherapy for a few years or more.

If a community member in serious difficulty refuses all suggestions for assistance, the leader can require a psychological assessment to determine how critical the situation is and gain insights into effective responses. Consideration should be given to others who work and live with persons in difficulty. If the troubled individual refuses options for healing and behaves disruptively, leaders may need to place certain limits on ministry and residence options.

Personnel ministry requires an ability on the part of the congregation leader to live with ambiguity. There is always a certain incompleteness in dealing with people, even while they are establishing some rootedness and direction. The gains are in the long term. The process of change is slow and depends on the right timing in the person's life. Acknowledging these realities helps the leader to become less perfectionistic and to approach persons less as a controller and more as an enabler and mentor.

Leaders have the personal capacity to deal effectively with all persons. One of the most humbling and critical areas of self-knowledge in personnel ministry is to know the people who "hook" you. For example, just as some members experience transference toward leaders, leaders may experience countertransference—in other words, the leader may relate to an individual as if he or she were someone significant from the leader's past. The leader must ask: "What chord is this person striking in me? What need or insecurity or anxiety in me results in my giving her this power? It is always wise to examine feelings and experiences in dealing with members: Am I unusually depressed, annoyed, bored? Do I intervene unnecessarily in a person's life (or avoid that person altogether)? Am I too much in need of a particular individual's agreement or appreciation?

Another "hook" can result from an unconscious overreaction to a person who seems to have characteristics the leader is afraid to acknowledge about himself or herself. Certainly, not all criticisms of others are projections of our own undesirable shadow traits. But if they involve excessive emotions, obsession, or overreaction far exceeding the perceived fault, something in the unconscious has been prodded.

If a leader debriefs regularly with a consultant or honestly brings overreactions to spiritual direction, he or she will be aware of countertransference or projection and can choose to react differently. If a leader is not able to transcend past history in personnel ministry to certain individuals, it may be more effective for another member of the team to relate to those persons.

Leaders should take charge of every personal crisis of their members. The need for crisis intervention usually generates conflicting and emotionally charged expectations on the part of the leader as well as the community member. Without a doubt, the leader will have to act swiftly and decisively at times

of crisis—but he or she does not have to be consumed by the crisis. The role of the leader in traumatic situations is to provide support and discernment as a companion to the affected individual, not to be a "hands on" crisis manager. A qualified administrator or other professional can assume the latter role, if necessary.

Many articles and other resources describe the formal intervention process. The ground rule is that intervention in another's life is necessary when that person is a threat to self or others (e.g., because of substance abuse, mental incapacity, or serious misconduct) and has not responded effectively to previous help. The basic steps of intervention are as follows:

1. A consultant or staff person researches avenues for the treatment of the community member and, after conferring with the leader, arranges for possible options for care.
2. The consultant or staff person prepares those involved and facilitates the intervention session; leaders and significant others are present.
3. During the intervention session, the leader offers the community member a choice of treatment options (e.g., consultation with a professional, participation in a treatment program, or care in an inpatient treatment facility).
4. While the member is in treatment, the leader provides support in ways recommended by professionals. (If the member was particularly hostile during the intervention, another member of the leadership team may act as the support person.)
5. One aspect of the crisis process that leaders sometimes neglect is support for those around the person in crisis—both at the time of crisis and upon that member's reentry into the community. Most inpatient programs recommend particular processes for providing such support and offer facilitation in implementing them. It is particularly helpful to give as much information to the member's residence group and coworkers as possible; for example, assure them that help is being given, that it is not their responsibility to counsel the individual, and that the appropriate approach for them is to support that person and treat him or her in a normal way.
6. During aftercare, the leader continues to support the member and usually enters into discernment with him or her about future ministry and other community-related issues.

SELF-CARE FOR LEADERS

As leaders commit themselves to maintaining a delicate balance in their challenging and rewarding ministry with community members, they should be making a firm commitment to their own self-care. I offer three principles of self-care that reflect holistic personnel ministry.

Know your capacity and set limits. The greatest resource the leader has is himself or herself. The most effective way for the leader to understand others and be compassionate with them is to be in touch with his or her own self and experience. The leader does not have to do everything—other resources are available. The use of a consultant can extend the leader's ministry potential.

Reflect on and integrate what happens in ministry. The leader may want to spend time daily in prayer and reflection on his or her ministry and share this faith experience with others. This is a time to consciously nourish the private self. Keeping in touch with at least one close friend can sometimes make the difference between feeling diffused and feeling anchored.

Be gentle with yourself. The leader must focus on a holistic lifestyle and spend time engaging in truly relaxing activities. If one has no element of margin in one's life (i.e., space between level of energy and responsibilities), there is no creative and recreative time for the spirit and body. When really stressed, the leader can relieve minor stresses over which he or she does have control.

Personally, I find that to the extent that I can live holistically, I am more available to my sisters in their joys and their sorrows. This is a powerful, humbling, and blessed experience that deepens my commitment and my prayer.

LEADERS' HELPFUL RESOURCES

When I was elected to congregation leadership at the generalate level, I was convinced, after my experience as a provincial and through my work with other congregations, that there had to be a way for leaders to avoid being consumed by their members' personal crises.

The need for another person to act as crisis manager and wellness coordinator was particularly true for our generalate leadership team, which came into office when our five provinces across the country were dissolved. The general officers had responsibility for personnel ministry throughout the United States and Taiwan. To assist in these responsibilities, we hired a full-time director of holistic health services. Qualifications for this position included experience in dealing with persons in crisis, psychological

credentials, and experience in pastoral ministry. Our director of holistic health services is a licensed psychologist who is not a member of the community. She is widely accepted throughout the community by members of different ages.

The director assists sisters and leaders during times of psychological crises by researching options for treatment (persons and places); preparing sisters for intervention and facilitating the process; arranging for care after a decision on treatment by the leader and by the sister, if possible; and coordinating aftercare if this is not provided by a treatment center. During medical crises, the director assists sisters in getting second opinions, looking at treatment options, and arranging for transfer to the motherhouse from the hospital after treatment. She has four part-time assistants in different geographic areas who provide presence and transportation during times of surgery, medical appointments, and physical therapy when members of the local community cannot provide these services.

The director of holistic health services also plays a consultative and educational role to members who may contact her directly about their medical or psychological concerns. She suggests the types of professional assistance that may be helpful and refers members to resource persons. She assists leaders in dealing with sisters and professionals on medical and psychological issues and is a mental health consultant to the staff of the retirement and health care center. We also ask her to inspire us to greater wellness and shared or lateral responsibility in times of need. She has also been helpful in writing articles on wellness, facilitating groups in building community and addressing conflicts, and offering workshops on such issues as aging, transitions, and conflict management.

The director has been particularly helpful to individual sisters and to leaders through the process of holistic assessment. A sister first shares her spiritual, medical, and psychological concerns with the congregation leader and then discusses her questions and needs with the director. The director then coordinates medical and psychological assessments—testing, interviews, physical examinations—with a professional team. The results of the assessment(s) are communicated in a team meeting. Present are the sister, leader, physician, psychologist, and director. After discussion and recommendations by all present, the sister may commit to a care plan or choose to discuss the recommendations later with the leader. Depending on the situation, follow-up conferences of the team may be held to monitor the effectiveness of the plan.

Another type of assessment the director conducts concerns the needs of preretired and retired sisters living away from the motherhouse. She visits with these sisters to determine if their physical and psychological needs can be met locally and then makes recommendations to the appropriate leader.

In addition to the director of holistic health services, we also use the consulting services of a psychiatrist and a medical professional. The psychiatrist offers psychological expertise and prescribes medication when indicated. The medical consultant has knowledge of a wide range of medical techniques and professionals for referral. Her most valuable assistance often is in her ability to penetrate the hospital system and assess appropriate care. Each of these consultants is available to both leaders and individual sisters and will speak directly to other professionals caring for a sister in order to clarify or monitor her care (with the sister's permission, of course). They clearly complement and enhance the ministry of leaders with their members.

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New Techniques for Religious Formation

Benedict Auer, O.S.B., D.Min.

In many monasteries and convents throughout the United States, it is not unusual to overhear a certain conversation between two religious after a junior religious has been asked to leave the community. The young person who was asked to leave had been very disruptive and caused much havoc within the community. One of the older religious expresses concern over some of the antics the community had to put up with during the two or more years of the young person's sojourn with the community. The other religious then usually makes a comment to the effect that the formation director had to give the young person sufficient rope to hang himself or herself. Finally, the first religious might say, "Why is it that today the community is often held captive by young people trying to enter the religious life?" This article is an attempt to answer that question and to offer some suggestions on how to forestall occurrences of being "held captive," or at least to help communities deal with them quickly.

STATE OF AMERICAN EDUCATION

At Saint Martin's College, a small Roman Catholic liberal arts college in Lacey, Washington, we have a large education division that accounts for roughly a third of the school's total enrollment. I work with students in teacher preparation—an exciting, if sometimes discouraging, endeavor. I have been teaching for over twenty-five years in every grade from preschool through graduate school, and I have been in vows for over seventeen years. As a late vocation (I was 36 when I entered the monastery), I had obtained a lot of my experience as a lay teacher in Catholic schools during my preconversion days. But within the last seven years, since I started teaching college, there has been a general revolution in education. The United States has become a country of labels—everything and everyone is labeled. Students are labeled for ADHD (attention deficit hyperactivity disorder), BD (behavioral disorder), ED (emotional disorder), and so forth. We have inclusion, multiage classrooms, and outcome-based education; as this article is being written, a dozen new ways to work with children in the classroom are probably being developed. When planning with my student teachers, I prescribe many different ways to work with problem children—from the Glasser's "reality therapy" model to the Cantor's "assertive discipline" model of classroom management, and all the options between.

During their internships, fledgling student teachers struggle with discipline, classroom environment, and multitudinous other problems. Inclusion has created many challenges for the classroom teacher, none of

which are insurmountable when sufficient knowledge is present and fear is dispelled through education of the staff, parents, and student. Special education is a field that is truly expanding, and its effects can be seen in many areas. The U.S. Department of Education now recommends that prospective teachers should major in elementary education, with an academic endorsement in reading or language arts and a second endorsement in special education.

I include all this background on the state of education in the United States because recently it dawned on me that religious communities may be unaware that some of this country's labeled children have grown up and entered religious life or are seeking admission. Many of these "disordered" people have become candidates at communities that are basically filled with people who entered religious life between the ages of 14 to 18 and had attended private schools in which reading and writing were central features of the curriculum.

A few years ago, Father Wulstan Mork, O.S.B., who had a way of expressing truth through humor, came into the recreation room of Marmion Abbey and said, "I have been teaching for thirty years or more, and I have finally realized the true Benedictine vocation. We have an apostolate to the barbarians, just like the medieval monks." This may have been an exaggeration, but I believe he was not too far off the mark. Today many high school students resemble the Visigoths—not in features but in their inability to read and write, their severe emotional and behavioral problems, and their apathetic approach to life. According to one of the speakers at the "Institute on Resilient Youth in the Violent World," held at Harvard University's Graduate School of Education last summer, "The United States is a country in denial." And religious communities may be in the same condition as the country: many religious deny that anything has changed since the 1950s except the numbers applying for admission to religious communities.

STATE OF RELIGIOUS RECRUITS

Many of the people coming to religious life in recent years are dysfunctional by anyone's standards, yet we often try to pretend that nothing has changed and everything is fine. The average American religious is bewildered and befuddled by many of the people seeking entry into religious life but tends not to vocalize his or her apprehensions. Examples abound to back up this statement. For instance, many young people in schools throughout the nation are angry. Anger is a major American problem. Therefore, many religious communities are accepting, even after screening, candidates who are angry, but very few communities have anger management programs in place. The average religious community is still using the old "osmosis" theory of religious acceptance: Come and visit us on a regular basis; you will learn about us, and we will learn about you. Nice idea—but the reality of today's candidates may not fit it. The "modeling" method of learning about religious life may not work for many young people who have learned to work the system. Passive aggression may not surface during a few visits or even an entire novitiate, coming to light only during a juniorate. Another serious problem is hyperactivity. Among the candidates seeking admission to our communities are individuals in constant motion—feet tapping, fingers twitching, unable to sit still.

What can be done about such problems remains for many communities a mystery. In the meantime, an entire community may be "held captive" by an individual who is hostile and often vindictive, and perhaps hyperactive as well. The actions of such individuals are often so subtle that they may be observed by only a small portion of the community. Those religious not sitting next to the candidate who is constantly tapping his feet may be totally unaware that there is a problem. This complicates the situation and often causes hard feelings because others may think the person describing the constant tapping is exaggerating.

I know of a number of convents and monasteries that have experienced the ultimate in being "held captive" with the suicide of a novice or junior nun or monk. Guilt after the suicide can be a devastating problem for a community. When I was in the seminary in the late 1970s, I became friends with a junior monk from another monastery who was a wonderful person but had deep-seated problems. The members of his community idolized him because they had not had a vocation for many years. He had a problem recognizing his inability to form close relationships, due to the death of his father and the remarriage of his mother. He could not articulate his feelings. His religious community, not unlike many others, was nonconfrontational and passive in its approach to the young man. They thought he'd grow out of the problem. They loved who they thought he was, not who he really was. The semester after I left the seminary, he hanged himself a few weeks before his thirtieth birthday. The community suffered a feeling of betrayal, yet here was a young man who did not know what to do, and a community with no measures in place to help him.

Most communities have outside counselors deal with their members' emotional and behavioral problems, and those counselors give outside answers.

Everyone in a religious community is part of the formation process —and part of any solution to problems within it

Communities tend to send juniors or novices off to counseling and then seem to think they have done their part. But deep-seated problems in an individual may require a renovation of a system or institution. Everyone in a religious community is part of the formation process—and part of any solution to problems within it.

MODELING IN COMMUNITY

When postulants or candidates enter community, formation directors often advise them to observe what is going on and to model their behavior on the monastic or religious behavior of other members. One problem with modeling is that many young people do not know how to do it. They are often insensitive to others and their needs. For instance, an only child will usually react differently to a situation than a child from a family of several children. Many of the religious already in convents and monasteries throughout the country are from families of three or more children; most candidates entering convents and monasteries today have no siblings, or perhaps only one. Most vowed religious are from families with two parents; many candidates seeking admission to our communities today are from broken homes or single-parent families. A result of modern forms of upbringing can be insensitivity—a serious issue for today's religious community. How does a religious community make a 30-year-old sensitive to the needs of the community, and vice versa? What does an individual religious do to help in the formation of potential permanent members? Everyone works carefully, yet with intent.

SPECIAL EDUCATION MODEL

I would like to suggest a model for formation directors that differs considerably from the modeling and "osmosis" methods. My suggestion, taken from special education, is to apply reflective direct intervention. I know that the classroom is different from the religious community, yet Saint Benedict does call the latter "a school of the Lord's service." And a religious community is truly a community of scholars and learners. We learn from each other. But for most religious communities, the old way of doing things is no longer working. We cannot continue thinking that things will get better without drastic change. It is time to try something new.

Certainly, the present model of frequent visitations for candidates is still needed. We cannot remove the obvious: people must experience our life in order to really know what we are about. Yet some questions are never asked of those seeking admission into community. Often our encounters with possible candidates are superficial rather than substantive. As a vocation director for eight years, I tended not to ask the right type of questions. I often was nonconfrontational. I tried to observe, but I was also teaching full-time and had additional jobs. If vocations are a community priority, then a full-time vocation director might be appropriate. Sometimes the vocation director and the formation director might be the same person, but certainly it would be ideal if they were two different persons. The vocation director should interview the potential candidate with questions that probe his or her social awareness and social skills. Does the young person interact well with community members? Does he or she speak only when spoken to? What are the candidate's fears? Does he or she ask probing questions? Is the interview a monologue instead of a dialogue? These are fairly obvious questions.

Observation is also important. For instance, the candidate's table manners give a picture that might point to a lack of social graces, if not skills. I remember one candidate who, when finished with eating, had more food around his plate and on the table than had reached his mouth. Such a problem can easily be corrected if the community wishes to address the issue—but often the community is critical in thought but not in action.

In the case of the sloppy eater, no one bothered to say a word to either the candidate or the formation director. Yet the correction would have been so simple. It could have gone like this: "Do you realize that as a religious, you will be invited to many different social occasions and eat with many prominent people? I think that you might need to brush up on your

table manners or at least be aware of how you are coming across to others who dine with you. May I suggest that you talk with Father S, and see what you might do to improve your table manners?"

Straightforwardness is not always a religious community's strongest point. Frequently, community members keep silent and continue to be miffed but never say a word. Straightforward talk is essential for good community relations. Thinking, "I won't say anything; eventually, he or she will catch on" just doesn't work any longer. We need direct intervention.

REFLECTIVE DIRECT INTERVENTION

Reflective direct intervention is a special education technique. Applied to religious life, it requires that either the formation director or a community member inform the candidate, novice, or junior exactly what the problem is and how it can be solved. This is done not in monologue but in dialogue. Unless handled well, this approach can be threatening. A young person may find confrontation difficult to handle at first. For instance, a young person may be used to wearing a variety of clothes in the outside world, perhaps favoring apparel in bold or fluorescent colors—attire that is not appropriate within community and is distracting to other religious. One can wait until the individual catches on to this (osmosis)—or simply help him or her through direct intervention.

Another common problem is noise volume within community. Many people coming into religious life today have never known a moment without background noise from a television, radio, or stereo, so they talk on a decibel level above normal conversational tone. Often they are unaware of what this means to a community that is accustomed to living in an atmosphere of prayerful silence and quiet. "They should catch on" (osmosis) would be the obvious response. But what if they have never been told that their noise is disruptive? Even if they are told about the problem, it will take time to resolve it—but if they aren't told, are they supposed to guess? Generally, people who have not been sensitized to others are not good at guessing.

The problems get worse as we leave behind such minor matters as table manners and loudness and get into bigger issues. Recently, a teacher told me about a youngster who came to class and refused to obey or listen to anything the teacher said. When the teacher told the child's mother, "Your son has no respect for authority," the mother answered, "Good. I have taught him that way." Fifteen or twenty years from now, if that youngster decides that religious life is for him, we have a problem. Not everything is done democratically in religious life. Things have changed a lot since Vatican II, but there are still times when we have to do things we do not wish to do or are told to do something for the good of the community. Freedom abounds, but no one is ever completely free. Therefore, problems with authority must be addressed, especially if a candidate feels anger toward authority. Of course, confronting candidates about their attitudes toward authority figures is a difficult task. Often, individuals with serious issues about authority are passive-aggressive as well. Frequently, religious superiors do not ask some candidates to do anything because they realize that these individuals will not comply. Whole communities have been disrupted by antiauthority behavior and superiors' failure to address it: community members unable to speak to each other, superiors denigrated by fellow religious, people in a constant state of anger.

INDIVIDUAL EDUCATION PROGRAM

In dialogue between the formation director, other members of the community, and the individual, a plan can be developed not dissimilar to a special-education-style individual education program. Such a plan would include a statement of the individual's present level of performance, a statement of goals, a statement of short-term objectives to support those goals, a statement of specific needs, a deadline for accomplishment of the above, a justification for why the plan is being followed, and information on who is responsible for what aspects of the program. For instance, a candidate has seemed quite angry lately. Discussions with her reveal that she finds herself unable to control her rage. What help might be suggested for her? Perhaps an anger management workshop, regular sessions with a counselor, or dialogue with a superior might be suggested, and steps might be taken to keep her informed of how she is perceived by the community. Included in this plan could be things to work on daily, weekly, and over the long term. The community also has an obligation to explore how the candidate views the community—romantically, realistically, with paranoia, or otherwise. This whole process requires an openness not found in many communities. It is tough to be honest—but without honesty, communities will continue to lose candidates, novices, and juniors.

The program I am suggesting is not something to be taken on without preparation. Present formation personnel should be allowed the luxury of training—not just in spiritual direction (although this is essential) but also in practical things such as anger man-

Present formation personnel should have training not just in spiritual direction but also in anger management, celibate behavior, assertiveness, and even special education strategies and techniques

agement, celibate behavior, assertiveness, and even special education strategies and techniques. Scripture warns us that not being as wise as the worldly is unwise. Unfortunately, however, we often are unwise. Today we must be as wise as the worldly if our communities are to survive and prosper in a healthy setting. We need to confront each other. The "osmosis" and modeling methods are not working for most communities. We need to shift gears. In a world dulled by the media, a world in which people often are numb from what they have experienced, we need to be much more forceful and open in dealing with problems within our communities.

Reflective direct intervention and the development of individual education programs may seem too behavioral for many formation people who prefer the model of religious osmosis. I suggest this approach not as a behavioralist but rather as someone who has lived in four different communities over the past twenty years and seen frustration grow into anger because issues concerning candidates, novices, and juniors are never addressed. When problems affecting a community are not addressed, they are not dealt with, and the community finds that it is being "held hostage" to itself and to the individuals presenting the problems. We must find effective ways to deal with troublesome issues. My suggestion is not to reinvent the wheel but to borrow from special education some techniques that seem to work. If we start to work on our problems by using already established and proven methods, we may be able to reverse the trend of attrition within our communities. Then maybe communities will not be "held captive" but will instead be free to pursue their goals with integrity and faith.

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Imaginative Theological Reflection

John C. Kemper, S.S., D.Min.

For the past several years, I have been involved almost exclusively with Roman Catholic seminary students in the areas of pastoral formation and field education. The candidate for priesthood today is very different from the candidate of twenty years ago. As J. Warren Holleran, M.A., S.T.D., notes in his article "Diocesan Priesthood Vocations" (HUMAN DEVELOPMENT, Fall 1993), today's seminarians are much older, they often enter the seminary with advanced degrees in various disciplines, and they represent the multicultural quality of the church at large. Second-career seminary students and international students are having an impact on the structure of seminaries in the United States, and the nature of the formation of such seminarians is being addressed within Roman Catholic theologates across the nation.

This article focuses on my experience of working with international students preparing for ordained priesthood and ministry in diocesan seminaries in the United States. The dominant factors that pose problems in international students' formation and education are language obstacles and inculturation difficulties.

Anyone who has studied another language knows that the attainment of true proficiency in that language can be a lifelong endeavor. Usually, international seminarians must successfully complete a difficult two-year program in English as a Second Language (ESL) before beginning the study of theology. Thus, international students generally enter their studies with an average reading knowledge of the English language and adequate speaking skills. At this phase in their formation, many of them encounter field education—a theological discipline almost unknown within Catholic theologates outside the United States and Canada. With the beginning of field education comes the task and expectation of theological reflection. Often, it is within the experience of theological reflection that problems of language skills and inculturation find expression.

Two examples come to mind. The first is that of a young Asian seminary student who was confronted for the first time with long-term institutional care for the elderly in the United States. This experience was more than foreign to him; it was offensive. From his cultural perspective, elderly people entrusted to long-term institutional care were "in storage, awaiting death." Visiting elderly patients in a nursing home required a great deal of energy on his part. The notion of long-term institutional care was an issue of inculturation that surfaced within one of his theological reflection sessions. The other example is that of a seminarian from Poland who, during an experience of clinical pastoral education, met a

What better way to communicate the presence of God than through the use of religious imagination?

woman who was studying for ordination within another religious tradition and who was a strong feminist—neither of which he had encountered in his native Poland or in the United States. In his reflection on the clinical pastoral education experience, he mentioned this encounter and indicated that he saw it as an opportunity for real personal growth.

NEW APPROACH ESSENTIAL

Given the complex challenges facing pastoral educators within Roman Catholic seminaries today, facilitating theological reflection is no easy task. Given the diversity within the student population that confronts seminary personnel today, new and creative approaches to pastoral education and theological reflection are needed.

The *Verbatim*, a basic tool that is often used within clinical pastoral education and supervised ministry experiences, has serious limitations when used with international students. It requires a dexterity with language and conversational skill that many international students lack. Another limitation of the *Verbatim* is that it can leave masked serious questions of inculturation for students who lack adequate language skills. The *Verbatim* is a vital tool for individuals who are working with their native language. The refinement of one's listening and responding skills is often the product of skilled use of the *Verbatim* within field education.

In responding to the student population within Roman Catholic seminaries today, pastoral educators need to find a more fruitful means of engaging international students and others in theological reflection. This new approach to theological reflection will need to be more creative, less structured, and less clinical. It will need to elicit the "feminine" side of the reflective process by becoming more free-flowing and permitting and encouraging the birthing and rebirthing of images. Theological reflection needs to incorporate more of the religious imagination if it is going to address fruitfully the situation of the international student.

Our Western understanding of imagination and our grasp of perceived knowledge have their origins in the writings of Plato and the allegory of the cave. We grasp what we are able to understand through our perception of the ideal. This is true when we discuss abstractions, such as motherhood or the holy. Our understanding of motherhood can, should, and ought to be colored by our perception of our own mother and of other individuals whom we know as mothers. Likewise, we can come to an understanding of the holy only after meeting someone who is holy and thus experiencing what is holy.

TAPPING IMAGINATION

Within the Catholic tradition is a wealth of wonderful images that contribute to what Andrew Greeley refers to as "the Catholic imagination." The treasure chest of the Catholic imagination is filled with images from stories and myth; from liturgy, sacrament, and ritual; from folklore and popular piety. In defining religious imagination, one cannot limit it to being simply a conduit for religious feelings and emotions. The religious imagination can communicate true, real data that the pastoral experience contains—and that revelatory data can communicate the actual presence of God within ministerial activity.

One of the goals of theological reflection is to find God in the actions of pastoral ministry. What better way to communicate the presence of God than through the use of religious imagination? In her book *The Inner Rainbow: The Imagination in Christian Life*, Kathleen R. Fisher writes that "it is in the level of imagination that we formulate our response to the encounter with the divine; faith finds expression first as myth and ritual, sacrament, symbol, image and story." Incorporating the religious imagination creatively into theological reflection frees the activity from being bound and confined by analytical language and permits the religious imagination to speak. This is a useful approach to reflecting with students who may not be working with their native languages—and it also presents a creative challenge to those for whom language is not an obstacle. The use of the religious

imagination forces students to move beyond the comfortable and safe confines of language into a whole new form of expression. When presenting their theological reflection, they should be encouraged to move beyond the use of the printed word to the use of images from the religious imagination.

In the reflection process, the facilitator can invite students to make use of religious images from art or to create their own images to capture the experiences they are sharing. The former is less threatening and still connects the world of the religious imagination and the act of theological reflection. For example, during his vocational struggle, a young, newly ordained priest found consolation and hope in reflecting on the image of *Jacob at Strife with the Angel,* painted in 1856 by Eugène Delacroix. For many individuals, contemporary forms of expression, dealing with colors and shapes, abstract forms and movement, dance and fire, can wonderfully capture the flowing movement of the third person of the Trinity. The images in religious art, past and present, are as varied as our pastoral experiences. An individual's selection process and shared rationale are equally important in the reflection process.

RICHNESS OF MULTICULTURAL IMAGES

As F. W. Dillistone emphasizes in *The Power of Symbols in Religion and Culture,* it is important to be open to the plurality that exists within the religious imagination. Images from many countries would be foreign to most North Americans. In embracing the diversity within the scope of art and expression worldwide, we reverence the various cultures that contribute to our religious imagination. Developing third-world countries, Central and South America, the Philippines, and Africa have produced art that is rich in meaning and could easily become material for theological reflection. One Latin American artist who comes to mind is Maximino Cerezo Barredo, C.M.F., popularly referred to as "the artist of liberation theology." Images of human hardship and struggle can become powerful conduits of communication for individuals experiencing similar difficulties within their ministry.

Another creative option in theological reflection can be the use of fabric. Over the past few years much has been written on the role of weaving in developing the religious imagination; Janet Schaffran and Pat Kozar touch on it in *More Than Words: Prayer and Ritual for Inclusive Communities.* Good fabric, skillfully woven by the hands of an artist of the loom, can be as rich a resource as any painting or sculpture. The plurality of material that can be incorporated into theological reflection is limited only by the human imagination.

A creative approach can greatly enhance the facilitation of theological reflection. Our religious imagination has so much to offer for reflection on our pastoral activity. We need to be open and willing to explore its richness as we continue to search for God in our ministry.

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The Circle Tightens

James Torrens, S.J.

The Stream

the noise a life makes in passing
its patter over stones

arriving, getting away
how it plummets, recuperates

its bright purity
its passing under shadow

from an unsleeping source
it streams

What a tonic it was, this past summer, to gather for what was billed as a "senior retreat" with my California Jesuit contemporaries. All of us, numbering about forty-five, are in our sixties. The spirit of that week was wholly upbeat. The reminiscences were not just nostalgic but composed a picture of past struggles to live by faith, moments of weakness perceived (their scars and bruises), and apostolic satisfactions.

The high point of our retreat was listening to the panel presentations of diverse foursomes who commented on religious life and vocation as they had experienced it. Some peppery discussions followed each panel. The chore of preparing for the future—for retirement or apostolic slowdown, for memory loss and creaking bones—got our attention too, but the principal focus was on gratitude for the time up to now. We had grown up before the modalities of faith sharing, but that is what engaged us.

One of the brethren obtained a videotape of *Babette's Feast* for us one evening. In this Danish movie, some elder disciples of a long-dead religious leader achieve forgiveness of one another and a general feeling of bliss with the help of French wines and a gourmet cook. Our cuisine, though decent, was not at that height; the rest of the experience matched perfectly.

For me, the frosting on the cake during the retreat was to go up the hill to the province infirmary of the Daughters of Charity to see Sister Esther, my sixth-grade teacher. Even while admitting to shortness of breath and memory troubles, she went on at length about past times. Her sparkle of humor keeps her very much in the present, and her peaceful depth of faith gives her a leg into the future.

A few weeks later our regional magazine for benefactors and spiritual associates, the *Western Jesuit*, published a "Jubilarian Issue." What a passel of oldies but goodies it featured—thirteen golden jubilarians, five priests who were sixty years in the Jesuits, and six marking fifty years of ordination. The editor had coaxed one-paragraph statements

out of most of them. These struck a celebratory note, as expected, but were also remarkably revealing and stirring.

Such reinforcements do not arrive in our lives without a reason. Our need for the assurances is not far to seek. We continue, in my order and my part of the country, to feel the tremors—that shaking of the earth familiar from the era of multiple departures from religious life. A number of our middle-aged members, much cherished and respected, have recently chosen a leave of absence from our midst. This is still troubling to me; the fabric of shared commitment and apostolate rips a little more each time.

The most outspoken of my brothers who have recently taken a leave refers to a quest for intimacy. It seems that day-to-day closeness to individuals, a kind of totally shared life and constant availability, is what they simply must have to feel human. I must admit that community life, despite all language glorifying the religious family, will by no means suffice for that. Even leaving aside the charge of sexual electricity that may be at issue, the expectation would be misplaced. There is something paradoxical about religious community. The real affective bond exists for some purpose outside itself—to foster missionary outreach and to dispose the members for aloneness with God.

This is important to get right. Something in the "heroic approach" of the past has too often eventuated in the formation of lone wolves, people absorbed in their own apostolic or other projects and in their circle of outside contacts—people who make their residence a kind of pious boarding house. In this model-which-is-not-a-model, frequent celebration of the Eucharist together, which should constitute the heart of the believing community, gets neglected. No wonder incoming members are put off by this view of community. No wonder they are few.

A disciple of Our Lord and servant of the gospel, man or woman, needs as much as any other human being to be known, appreciated, and loved. We have to ask, Is our religious group, or clergy fellowship, nurturing that? Does it offer brothers or sisters or fellow priests to whom one can relate as good friends in the Lord, to whom we will stay bound by interests and outlooks instinctively shared?

There is, therefore, closeness and closeness. The more preoccupying and physical sort is beyond the reach of religious community life, which by definition fosters a certain aloneness with God. The sacrifice of intimacy is what one feels most acutely in that species of commitment. It gives an ache to certain hours or days, at times sets the fantasy going. It may push one toward quasi intimacies. But if met honestly and with some grace, these moments in our lives can lead also to a renewal of commitment, a rekindling of divine love, which is supposed to be our end-all and be-all.

The value of our "senior retreat" at Los Altos was to help those of us in our sixties rediscover the kind of mutuality that is our vocation. It was a grace to be with so many who know us well and (nevertheless) like and esteem us. Among that number are a precious few to whom we stay particularly close. With these, not obsessively but familiarly, we can pray and chat. However often we may cringe at the ring of the telephone, upon hearing their voices we relax. They confirm us in our dedication; we accompany them in their good times, besides standing by them in dark days.

Given this model for shared discipleship—however limping be its realizations—it really is hard to see others leave the circle. That is where my own reactions of dismay or even anger can come from—which are uncalled for, because these people, after all, have made a commitment to God, not primarily to me. But those who do step away from a smaller circle, it turns out, mostly stay in a larger one—the larger zone of attraction. This is another thing one finds out over the years. These former partners merit our affection, and themselves feel the bond, still.

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The Addictions of Clergy and Religious

Harry C. Cronin, C.S.C., Ph.D.

To engage in the task of exploring the phenomenon of addiction as it occurs in the Catholic priesthood and religious life brings the inquirer face to face with two intractable difficulties: abundance of denial and poverty of language.

The disease of addiction—any addiction—inevitably occurs hand-in-hand with the vexing phenomenon of denial. If I am suffering from an addiction, I will not only deny that I am addicted; I will even deny that I am suffering. When exploring the possibility of addictive systems occurring in the religious life and in the priesthood, the denial is further complicated by an absence of adequate language. How can addiction occur in this most sacred life, this holiest of places? Addiction connotes excess—even sinful excess—along with the personal and social destruction that must inevitably follow it. Addiction connotes instincts, passions, and behavior out of control. The religious life and the priesthood have connotations exactly the opposite: discipline, self-sacrifice, prayer, and ministry. How can a priest or religious be an addict and still be a priest or religious? Or, more to the point: How can the religious life indeed be religious—or even healthy or decent—if it can become the home, locus, and matrix for addictive lifestyles?

FRACTURE OF DENIAL

During the 1970s the Catholic priesthood and religious life did indeed begin to admit the presence of addictions. During that decade, dioceses and religious orders began to publish and implement policies on alcoholism. Two circumstances forced this long-overdue but inevitably redemptive process. First of all, the secular world—particularly the business community and the military—began to see the rehabilitation of the alcoholic individual as a positive advantage. Rehabilitation of the alcoholic was seen to be more cost-effective than training a new person for the job. Second, in the wake of Vatican II, the priesthood and religious life were under a scrutiny they had never before sustained. The systems of denial that had previously protected the alcoholic priest and religious ("Father isn't feeling well today"; "Sister has a very bad cold") were simply no longer effective. Policies were published. Health committees were established to implement them. Priests and religious entered treatment.

The result of this initial fracture of denial was a new and unexpected form of renewal. Many priests and religious entered recovery programs and found not only a new life but also a new religious life. They became apostles of recovery, and the religious

communities and dioceses in which they lived experienced a renaissance of honesty—and relief. If the problem of alcoholism could be solved, perhaps other seemingly intractable difficulties could be solved as well.

ADDICTION TO MOLESTATION

The 1980s, however, brought another and more disturbing crisis. Catholic lay people became all too familiar with the image on the evening news of priests sitting in courtrooms—sometimes in handcuffs—accused of child molestation. For all Catholics, this phenomenon threatens to become a crisis of credibility and a crisis of our corporate conscience. For the press, it is a feeding frenzy. What is not generally recognized is that the problem of habitual child molestation is exactly like alcoholism: it is an addiction. But unlike alcoholism, it is an addiction to a process rather than to a substance. Whatever else repeated child molestation might be, it is at base a form of sexual addiction and an especially disturbing sign that priests and religious are susceptible to addictions in general.

In his book *The Sexual Addiction,* in referring to the sex addict whose compulsion happens to take the form of child molestation, Patrick Carnes states, "There is little compassion or understanding for someone compulsive at this level. Yet, addiction exists here, too. Whether or not there should be compassion or understanding is another issue. That addiction exists here is a fact."

We have chosen to treat child abuse as an outrageous evil rather than an addiction. In fact, it is both. But in failing to acknowledge its addictive nature and the implications of such an admission, we have created a new system of denial. The principal reason for the priest-as-child-molester phenomenon is not that certain priests and religious are prone to this excess and others are not. What this article attempts to show is that child molestation exists in the priesthood and religious life because the lifestyle itself can be and often is a home, locus, and matrix for addictive lifestyles. In dealing with the problem of molestation, we have concentrated all our efforts on the affected individuals. We have avoided critical examination of the system itself—the priestly and religious life that unwittingly supports the addiction.

Why this is so and what the implications are will become clearer as we explore one of the most important—and intriguing—developments of the past few years in the field of addiction: the rapid and radical evolution of the concept of codependence.

DISEASE OF CODEPENDENCE

Originally, the word *codependence* was used to define the condition that developed as a consequence of living with an alcoholic or a drug addict. Our understanding of the concept has evolved to the point that it is now viewed as a separate addiction and the primary disease in all addictive processes.

Twenty years after the foundation of Alcoholics Anonymous, an organization called Al-Anon was formed for the family members of alcoholics. It was founded on the premise that those who live with an alcoholic need help, just as the alcoholic needs help. Gradually, this concept developed further to view alcoholism as a family disease. The entire family needs to be treated, both the alcoholic and nonalcoholic members.

In the late 1970s, through the leadership of an active and well-funded government agency, the National Institute for Alcohol Abuse and Alcoholism (NIAAA), the prevention of alcoholism became a primary concern. It was found that adult children of alcoholics were at least twice as likely to become alcoholics as the children of nonalcoholic parents. This phenomenon became a focus of promising study in the interest of prevention, and some intriguing patterns began to emerge.

Researchers observed that the majority of adult children of alcoholics seem to develop consistent and predictable patterns of behavior. This finding encouraged the application of the theory and language of family dynamics to the alcoholic family, leading to the now-familiar catalogue of roles assumed by adult children of alcoholics: primary enabler, hero, lost child, rebel, mascot.

Thus, alcoholism was linked with familial dysfunction. Yet it became obvious that the patterns noted in alcoholic families could easily be found in other families as well—families completely untouched by alcoholism. This raised a major question: Did alcoholism cause the dysfunctional family, or did the dysfunctional family cause alcoholism?

As research continued, the focus began to switch from individuals to events: from affected persons to family conditions. A new truth began to emerge. The addicted family member was no longer seen as the primary villain. The primary villain was thought to be the trauma perpetrated by the addicted family member—the alcoholic father or the drug-addicted older brother. But trauma can be caused by other distressing events as well: child abuse, divorce, early loss of a parent. Children who are traumatized in their early years and grow up in an atmosphere of dysfunction can develop any number of pathological responses and coping devices. One such response

What other lifestyle could possibly contribute more effectively and efficiently to a disease of lost selfhood than that of the priest or religious, in which selflessness is one of the distinguishing hallmarks?

might be the development of an addiction, whether to a substance or a behavior.

As a result of this shift in researchers' thinking, the child of alcoholic parents became a subspecies of the wounded inner child. Codependence was no longer seen to be simply the by-product of living with addiction; it was recognized as a causal agent (although certainly not the only one) of addiction. Many dysfunctional conditions could be traced to codependence, investigators contended; addictive behavior was only one of them. As Charles Whitfield writes in *Substance Abuse: A Comprehensive Textbook* (edited by Joyce Lowinson et al.), "Co-dependence is not only the most common addiction, it is the base out of which all our addictions and compulsions emerge. Underneath nearly every addiction and compulsion lies codependence. . . . Whichever form it may take, the addiction or compulsion becomes the manifestation of the erroneous notion that something outside ourselves can make us happy and fulfilled."

Codependence, therefore, came to be seen as (1) a condition brought about by childhood trauma, such as living with an addicted family member; (2) a condition that, in its manifestation, is so close to addiction as to qualify as an addiction itself; and (3) a condition that sometimes can be one of several causal agents for the development of other kinds of addictive behavior. As the concept of codependence has evolved and developed, so has its application. It has been expanded almost without limits—and, one might say, almost without mercy. In her book *When Society Becomes an Addict,* Anne Wilson Schaef declares that our society itself is addictive, along with the organizations within it: "The context of . . . our society is the fact that the system in which we live is an addictive system. It has all the characteristics and exhibits all the processes of the individual alcoholic or addict. It functions in precisely the same ways."

DYSFUNCTION IN MINISTRY

Schaef's paradigm was applied almost immediately to the church. Other writers, using Schaef's writing as their starting point, began to identify certain aspects of church life and church structure that were clearly codependent. In an article entitled "Dysfunctions in Ministry" (HUMAN DEVELOPMENT, Spring 1992), Thomas Frazier points out three specific types of church systems that are dysfunctional and codependent:

1. Church systems that adopt an unrealistic or grandiose sense of mission that "implies ministry philosophies so extensive in their scope that mere mortals have difficulty delivering them." In other words, many church structures do not provide priests and religious with a realistic sense of what they can or cannot do. Instead, they tend to allow themselves to be defined by the needs of those around them. They can therefore become other-directed to a truly pathological extent.
2. Church systems that lead to lives that lack balance and "[encourage] the development of more service programs based on an inflated sense of mission without a realistic assessment of the limitations and wellness of the staff."
3. Church systems that foster an atmosphere in which self-denial is overemphasized: "Ministers who are likely to be entrapped by the dysfunctional sense of mission of a system that demands too much are ministers who have not emphasized the value of their own well-being. . . . Consciously, religiosity is used to justify long work hours and compulsive work habits."

Sean Sammon, in his book *Alcoholism's Children: ACOAs in Priesthood and Religious Life,* explains in great detail how the same roles adopted by members of alcoholic families are often assumed by individuals in the priesthood and religious life. One example:

> Some women religious trade the role of hero at home for that of an overly responsible community member. Overextending themselves continually, most plan to do more in an average day than could ever be done realis-

tically; they fail to realize that a twelve-hour day is not a half day's work. These women, and many priests and brothers, were taught that 'good' priests and religious should always be available. They never say 'no,' fail to set realistic limits, and keep busy and overwork. Burnout is a constant danger. Their spirituality is often shallow. While they may look like saints, their sanctity has a compulsive quality: they have to be good.

That the religious life and priesthood are prone to codependence in a major way should become clear upon considering Whitfield's definition of codependence as "a disease of lost selfhood. . . . any suffering and/or dysfunction that is associated with or results from focusing on the needs and behaviors of others."

What lifestyle is more focused on the needs of others than that embraced in both religious life and priesthood? What other lifestyle could possibly contribute more effectively and efficiently to a disease of lost selfhood than that of the priest or religious, in which selflessness is one of the distinguishing hallmarks? To focus on the needs of others in an appropriate and healthy way is to be engaged in useful ministry. But to do so in an unhealthy way, a way that effectively obliterates the self, is to become an unhealthy codependent. And ministry, unfortunately, becomes pathology. Frazier expresses this as follows:

> Ministry systems often have characteristics typical of addictive organizations and may at times pressure ministers into compulsive behavior. . . . Those who tend to be compulsive or perfectionistic in their ministry as a result of unexplored, unresolved issues relating to their family of origin often place an emphasis on self-denial as opposed to self-development. Consciously, religiosity is used to justify long work hours and compulsive work habits.

In his article "Dysfunctional Clergy and Religious" (HUMAN DEVELOPMENT, Winter 1990), David O'Connor identifies five specific dysfunctions often found in religious: perfectionist tendencies, stressful lifestyle, lack of development, neglect of human need—and, most significantly, substance addiction.

Addiction is present in the priesthood and religious life precisely because the lifestyle itself is, by its very nature and history, unusually prone to the development of codependent systems, behaviors, and attitudes. Consequently, it is also prone to the development of addictions.

In the remainder of this article, I will concentrate on four specific addictions and explore how they tend to play themselves out in the priesthood and religious life. Two of them are substance addictions: alcoholism/drug addiction and compulsive overeating. Two of them are process addictions: sexual addiction and workaholism. For the purposes of this discussion, I will define addiction as a pathological relationship to a mood-altering behavior or substance —a relationship that tends to destroy all others.

WORKAHOLISM

Codependent and dysfunctional systems in the priesthood and religious life are most obviously manifested in workaholism or work addiction. As Barbara Killinger observes in *Workaholics: The Respectable Addicts,* "The roots of workaholism lie in the old Calvinistic philosophy that work redeems the believer and that indulging in pleasure, especially the pleasures of the flesh, will bring eternal damnation. Even three hundred years later, this joyless dictum that work is virtue and play is sin still pervades our society."

We Catholics have found our own theological justification for workaholism. Prayer is the way to achieve union with God, and *"laborare est orare"* (to work is to pray). Therefore, to work is to achieve union with God. For persons committed to celibacy, however, this concept can be the basis for truly dangerous consequences. In an article titled "Church Professionals and Work Addiction" (*Studies in Formative Spirituality,* May 1987), Martin Helldorfer writes that "within the lifestyle, it may be difficult to achieve recognition, receive affirmation, and to have a sense of being valuable except by proving oneself in work."

For many workaholics, work is a substitute for religious experience. The knowledge that one is working beyond one's capacity can bring with it a surge of adrenaline that acts like an externally administered drug to induce a sense of ecstasy. In the book *Personality Fulfillment in the Spiritual Life,* Adrian Van Kaam notes that because the religious life places such a high premium on success, the work addict can practice his addiction to receive the reward that caused the addiction in the first place: acceptance. Killinger concurs: "Excessive work, with its adrenaline high, hooks the workaholic, and a compulsive need for approval drives him or her to stay busy, be productive and enjoy the accolades that hard work receives in our society. . . . workaholics cannot not work without becoming anxious. The 'work persona' (the image they wish others to see) thus begins to dominate their own lives."

It would be difficult to overstate the extent to which the priesthood and religious life support and enable workaholic behavior. Instead of being recognized as needing help, workaholics are usually rewarded. They are more likely to be viewed as saviors than as sick individuals. And the potentially deadly condition of "burnout" is too often seen as an unfortunate accident rather than what it really is: the inevitable consequence of an addiction.

It should not be surprising that religious—living a life in which reward systems are suspect or nonexistent—will unconsciously and unintentionally seek rewards in substance abuse

ALCOHOLISM AND DRUG ADDICTION

According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, addiction or dependence is identified when certain well-defined symptoms occur. These symptoms have to do with thoughts, actions, feelings, and sensations associated with the regular use of certain drugs: alcohol, sedatives, stimulants, and opioids.

These symptoms may be seen in patterns of use. For example, addicts may use more of a particular substance and may use it for a longer period of time than expected. They may unsuccessfully try to stop using it or cut down. They may spend a great deal of time either using the substance or recovering from its effects.

Addicts may continue to use a substance despite its adverse effects. They may give up other activities in order to use the substance and may neglect responsibilities because of either use or withdrawal of the substance.

Individuals truly addicted to a substance develop a physical tolerance to it, and when their use of the substance ceases (either voluntarily or involuntarily), they experience withdrawal symptoms.

Three aspects of the priesthood and religious life heighten vulnerability to alcoholism and drug addiction: the absence of any reward system; the fact that there are no in-place mechanisms to officially deal with dissatisfaction; and the fact that there is, in general, a lack of interest in making priests and religious aware of their own competence.

Even though the actual cause of alcoholism and drug addiction is still disputed, there is general agreement that it has to do with the extent to which addictive drugs activate the body's reward system. The priesthood and religious life, unfortunately, have no reward system. A recent study of Catholic clergy by Dean Hoge and coworkers identified "lack of reward" as the primary cause of stress. The clergy usually work for little or no salary and certainly receive no merit increases. There are no automatic promotions. There are no formal, established, or institutionalized ways to reward the priest or religious for a job well done. The only reward is the life itself, or the knowledge that one is doing God's will, which religious value in and of itself. Thus, it should not be surprising that religious—living a life in which reward systems are suspect or nonexistent—will unconsciously and unintentionally seek rewards in substance abuse.

A November 1992 report in the *Harvard Mental Health Letter* indicates that alcoholism and drug addiction are less likely to occur in people who are "reasonably happy with their work, their family lives, and their place in the community." In the priesthood and religious life, there are no grievance committees. If a person is unhappy, there is usually no official process of redress.

According to the same report, the likelihood of alcoholism and/or drug addiction increases when an individual has no sense of his or her own competence: "Addiction is said to develop when a drug supplies the only experience that strengthens a person's feeling of competence." When the priesthood and religious life fail to provide formal and official affirmation, and when they fail as well to provide adequate mechanisms for dealing with grievances, then the possibility of alcoholism and drug addiction increases.

SEXUAL ADDICTION

Patrick Carnes has written and lectured extensively on the subject of sexual addiction. He describes it in the following terms in *Out of the Shadows*: "The [sex] addict substitutes a sick relationship to an event or process for a healthy relationship with others. The addict's relationship with a mood-altering 'experience' becomes central to his life." In other words, for the sex addict, the reproductive system is transformed into a mood alterer, a drug. It is no longer the basis for creative and loving relationships; it is used for itself alone. The object the sex addict seeks is not pleasure. For the addict, sex is a painful and humiliating experience, devoid of genuine pleasure.

What the addict looks for in sex is the element of

risk and danger. For this reason, the "levels" of sex addiction are defined according to the social acceptability of certain sexual practices: the less social acceptability, the more danger. As the addict ascends the scale from the lower levels of addiction (masturbation, pornography, prostitution) to the upper levels (incest, rape, child molestation), the progression is marked by increasing risk. The more risk, the more excitement; the more excitement, the more attraction. The addict who is addicted to child abuse, as opposed to the compulsive masturbator, is addicted to dangerous and risky sexual behavior—not because such behavior is sexual, but precisely because it is risky and dangerous.

Persons who engage in such behaviors do not do so because they relish sexual pleasure; they do so because they hate themselves. This self-hatred causes them to focus destructively and relentlessly on objects outside themselves. In these individuals, the basic disease of codependence has developed to an especially dangerous and damaging degree.

There is certainly no evidence that sexual addiction is any more prevalent in the priesthood and religious life than in any other population. Counselors and confessors who do extensive work with priests and religious generally agree that sexuality is a serious adjustment issue for a large number of priests and religious, although they may not see it in specifically addictive terms. Information about the prevalence of sexual addiction among priests and religious must of necessity be anecdotal; there are no validated statistics. But such statistics, even if they were available, would hardly tell the whole story. There are, statistically, a very small number of priests and religious convicted of child molestation. But this small number has effectively changed the public image of the priesthood.

A WAY TO REDUCE SHAME

Sex and Love Addicts Anonymous, the basic text for participants in the twelve-step program of the same name, contains the following intriguing statement in its discussions of step one: "We admitted that we were powerless over our sex and love addiction and that our lives had become unmanageable. Most of us had attempted at various times a wide range of strategies to control our behavior. . . . We had religious conversions, sometimes choosing a monastic life where sex would not be available." The rationale behind this statement is quite obvious: if a person is having trouble controlling his or her sexuality, what better solution than to adopt a lifestyle that requires celibacy? Mark Laaser, who has worked extensively with sexually addicted church workers, maintains that like all sex addicts, they are looking for ways to reduce their sense of shame. Priestly ordination and religious profession can be central features of a shame reduction strategy.

Many religious and priests convicted of child molestation represent the most public manifestation of sexual addiction, but there are others. The priest or religious who compulsively and destructively masturbates, uses pornography, or engages in illicit affairs is a less public but no less painful example. Priests or religious can become involved in obsessive, crippling relationships, sometimes with other priests or religious. These relationships tend to be exclusive, excessively dependent, and productive of personal growth only when terminated. Sometimes these relationships are sexual; sometimes they are not. Perhaps the new taxonomy of religious life should include "healing from addictive relationships" rather than "avoiding particular friendships." And perhaps, along with prayer and spiritual discipline, the director or confessor could gently advise the priest or religious afflicted with such difficulties to become involved in a twelve-step program that deals with sexual addiction. To identify an addiction is not to condemn; it is to present an invitation for healing.

COMPULSIVE OVEREATING

In an article entitled "Sexual Addiction and Clergy" (*Studies in Formative Spirituality,* May 1987), Laaser notes that "food addiction involves the compulsive pursuit of a mood change by engaging repeatedly in episodes of binge eating despite adverse consequence." Most food addicts are thought to have a chemical imbalance that results in their addictive use of food. This chemical imbalance, joined with early childhood trauma and its resulting codependent behavior, produces the following effects:

1. An obsession with food. This is not only an obsession with eating; it can also be an obsession with the buying and preparing of food. The thought of food becomes all-important and all-encompassing. Food becomes the dominant thought for the addict, and all action moves ultimately toward the dominant thought. Food controls the thinking process.
2. A mental obsession with food is linked with a compulsion. Not only are food addicts unable to control their thoughts about food; once they begin to eat, they are unable to stop. The meal or snack becomes a binge. As Kaye Sheppard points out in *Food Addiction: The Body Knows,* addicts cannot control when they eat or how much they eat. They can never predict any activity related to eating.

The denial system for the food addict is dictated by society. We put enormous emphasis on physical attractiveness. The bumper sticker featuring the words FAT CHICKS inside a circle with a diagonal line through it characterizes perfectly and succinctly our attitude toward overweight people: they are the modern lepers. Thus, in the food addict's complicated denial system, the problem may not simply be compulsive overeating. The problem may have to do with being overweight. Some food addicts are likely to be compulsive about dieting—which, ironically, increases rather than decreases the obsession with food. Food addicts may also be addicted to exercise.

The denial system for food addicts can take dangerous forms. They may, for example, become involved in a binge/purge cycle—that is, gorging on food and then inducing vomiting. They may try to hide their eating. But like any other addiction, the outcome of food addiction is ultimately lethal. Addictions eventually kill the body—but only after they have killed the spirit.

There is probably no public lifestyle more tolerant of the compulsive overeater than that of the priesthood and religious life. The overweight priest or chubby sister is an object of indulgence and delight, often perceived as a sort of folk hero. This is based on the strange but nonetheless inevitable projection that fat people seem happy (at least, we think they ought to be). The gift most commonly given to priests and religious is food. Overweight among religious is seldom, if ever, evaluated for what it is: the tragic cover-up of pain.

TOWARD RECOVERY

These reflections on addiction in relation to priesthood and religious life are not meant to be critical or condemnatory. If indeed the priesthood and religious life involve an environment particularly vulnerable to codependence and addiction, then the solution is obvious: the lifestyle must renew itself.

The fact that priests and religious are vulnerable to addiction simply shows that they are human and subject to the most human of failings. The gospel is not a primer on codependence. It is the world's first and most authentic story of true love—a love that is courageous and self-sacrificing, without the slightest trace of codependent victimization or self-pity. Codependence is a parody of the gospel. To cleanse the priesthood and religious life of their codependent and addictive elements would be to bring them more directly and more purely into the gospel's light—a simple and obvious form of renewal.

But the process is not simply one of discovering the addict and sending him or her to treatment. The priesthood and religious life must admit that our lifestyle, for all its goodness and virtue, is conducive to addiction because it tends to foster codependence. Admitting the problem, however painful that may be, is always the first step toward recovery.

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A Close-up Inspection of The Multiple Personality

Richard P. Vaughan, S.J., Ph.D.

The past couple of decades have seen a dramatic increase in the number of publications, both professional and popular, about people who seem to have not one but several personalities. Perhaps best known are the biographies *The Three Faces of Eve* and *Sybil,* both of which have been made into films. Each of those biographies describes the life and behavior of an individual who seems to have a number of personalities living and acting within the same physical body. Each of these personalities has the ability to come forth and control the individual's mind and actions for a time, then disappear as another personality takes its place.

The intent of this article is to acquaint pastoral counselors and spiritual directors with the mental life and behavior of a person with a multiple personality disorder, to suggest ways to detect this disorder, and to indicate what counselors and directors can do to help people with this disorder.

DEFINING THE DISORDER

Multiple personality disorder (MPD) is a pathological condition in which the primary personality becomes fragmented into two or more secondary personalities—each with its own way of thinking, feeling, and acting—that alternately take control of the individual's thoughts and actions. A person with MPD is not merely acting a part, nor are several fully developed personalities operating within his or her body. The individual with MPD seems to construct in his or her mind, and then somehow become, one or more split-off personalities distinct from his or her original personality. Unlike the original personality, these conjured-up personalities are not complete. Each seems to remain at a particular chronological age and usually does not continue to develop as does the original personality. An individual's split-off personalities may be of either sex and may range widely in age (e.g., a small child and an old woman).

REVISED CLASSIFICATION

In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),* the condition widely known as multiple personality disorder is reclassified as dissociative identity disorder (DID). The reclassification is the consequence of what has been a sometimes bitter controversy among some professionals over the validity of classifying MPD as a distinct personality disorder, plus the ambiguity of the term *personality.* The new description of the disorder in the *DSM-IV* emphasizes the mechanism of dissociation and uses the terms *identity* and

personality state: "the essential features of the dissociative identity disorder are the existence of two or more distinct identities or personality states that concurrently take control of behavior. Each of these identities or personality states is experienced as if it has a distinct personal history, self-image, and identity, including a separate name." The previous edition of the *Diagnostic and Statistical Manual (DSM-III-R)* describes MPD as "a mental condition in which there exists within the person two or more distinct personalities or personality states." Because the disorder has long been popularly known as multiple personality disorder, and because almost all the literature to date refers to it as such, I shall refer to it as MPD in this article, and I will use the term *multiples* to refer to individuals with MPD.

ALTERNATE PERSONALITIES

In a dissociative disorder, "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment takes place" *(DSM-IV)*. This disruption splits off the previously controlling, primary personality or a secondary alternate personality from a newly established alternate personality, so that the individual is aware only of the new alternate and not the previous personality or alternate (hence the use of the term *dissociative*). MPD is characterized by two or more seemingly separate identities or personality states successively taking over and controlling an individual's thoughts, feelings, and actions. The number of alternate personalities can range from two to over one hundred. Half the people with MPD have less than ten alternate personalities. More often than not, these alternates have names, but sometimes the multiple does not reveal their names to other people. For a period of time, each alternate takes control of the individual's mind and actions; then another alternate takes its place.

When the individual with MPD switches from one alternate to another, there is usually a gap in the memory; he or she has no recollection of what took place when the previous alternate was in control. In addition, under the control of any given alternate, the multiple seems externally to become a different person: his or her ways of thinking, feeling, and acting are not the same as those determined by the previous alternate. The individual suddenly wakes up in a new world and loses all recollection of the previous alternate's world. For the most part, a multiple stays with the same alternate for a long period of time, sometimes even for months. The switching of alternates usually takes place under some kind of severe stress, either real or imagined.

Each alternate has its own distinct worldview, which is somewhat different from that of the primary personality and those of all the other alternates. Often, however, a number of the more frequently used personalities are similar in characteristics and behavior. As a consequence, many counselors fail to notice a multiple's switching from one identity to another. In severe cases, the original, core personality is totally covered over by new alternates, and the multiple's thinking and way of acting are always governed by one or several dominant alternate personalities. Usually, it is only when such an individual switches to a radically different alternate—for example, from an adult alternate to a child alternate—that a counselor may begin to recognize the psychopathology.

THE HOST PERSONALITY

Frequently, a couple of dominant alternate personalities control the multiple's thinking and behavior most of the time. The dominant alternate, when it is in control of the individual, is called the host personality. In some cases the host personality is the original, core personality, but more often it is not. It should be noted that the host personality can give rise to a number of other alternate personalities—hence the large number of alternate personalities in some multiples. A multiple may have three or four frequently used alternates that are quite similar in characteristics and not easily differentiated; this may account for the fact that some multiples undergo psychotherapy for as long as three years before they are diagnosed with MPD. Therefore, it should not be unsettling to pastoral counselors or spiritual directors that they seldom, if ever, become aware of the presence of multiplicity while interviewing their counselees or directees.

A 28-year-old secretary came to her pastor and asked for help with her state of depression. In the first session, she spoke, dressed, and acted like a college sophomore and appeared to be much younger than her actual age. When she returned for a second session, she seemed to be an entirely different person, not only in the way she acted but also in her appearance. Her facial features, hairstyle, and mannerisms had changed: she spoke, dressed, and acted like a mature businesswoman and looked much older than she had at the previous session. She also seemed to have no recollection of what was discussed at the first session. Between sessions she had switched from being a college coed to being a mature businesswoman. Although the counselor noticed the difference, he passed it off as a change in hairdo and makeup.

CHARACTERISTICS OF THE MULTIPLE

A person with MPD may manifest from two to as many as one hundred different alternate personalities; the average number of alternates ranges from thirteen to sixteen. Women with MPD outnumber men with the disorder by six to one. Although most multiples are first diagnosed with MPD between the ages of 25 and 35, it is thought that the disorder begins in early childhood.

A survey of a hundred MPD cases, conducted by the National Institute of Mental Health (NIMH), found that 97 percent of the subjects reported having experienced significant psychological and physical trauma during childhood. Incest was the most commonly reported trauma, followed by other forms of sexual abuse, physical abuse, a variety of emotional abuses, and extreme neglect. Another cause of MPD was witnessing the violent death of a parent or sibling. In most of the cases reported in the NIMH survey, the multiples experienced a combination of sexual, physical, and emotional abuse. At present, there is not sufficient research data to demonstrate conclusively that traumatic abuse and neglect in childhood cause MPD, but the evidence gathered so far definitely points in that direction.

A typical case history of an individual whose MPD stemmed from childhood traumatization reveals the extent of the abuse she endured over a prolonged period. For that individual, there seemed to be no escape other than to create an imagined person whose life was free of terror and abuse, and then to take on the conscious life of that person through the unconscious mechanism of dissociation.

Amelda was an emotionally disturbed 26-year-old woman who came to a mental health clinic because she was in a serious state of depression and contemplating suicide. She told a therapist that she was the only child of her mother's first marriage, which ended in a bitterly fought divorce. Almost from the beginning of her parents' marriage, Amelda's father had physically and emotionally abused her mother, and Amelda had witnessed much of that abuse.

With the breakup of her parents' marriage when Amelda was four years old, her mother began living with a man who made pornographic films of children —and he used Amelda as one of his principal subjects. During the filming, if Amelda cried or protested, her mother threatened her with severe punishment, which she sometimes carried out.

From the ages of 4 to 9, Amelda was often neglected, kept in her bedroom most of the time, and not allowed to play with other children. Frequently, Amelda was beaten by her mother for no reason she could understand. Almost nightly, her mother's live-in partner came to Amelda's room, sexually abused her, and threatened to kill her mother if she ever told anyone about it. Eventually, Amelda came to blame herself for what was happening and regarded herself as bad and deserving of punishment.

When Amelda was 9 years old, her mother left the live-in partner and began another relationship—which, although hardly compatible, eventually led to marriage and a more stable, less terrifying life for Amelda. Nevertheless, by the age of 15, Amelda was a high-school dropout with no friends, feeling very much alone. Later she held a variety of low-paying jobs but either quit or was fired because of her depressions or her inability to get along with other employees.

PREVALENCE OF MPD

Once considered a rarity, MPD is now thought to be much more prevalent. In the past decade, an extensive body of research articles and books on the disorder has been published. About ten years ago, Philip Coons reported that there were 6,000 diagnosed cases of MPD in North America and indicated that there were probably many more cases undiagnosed or diagnosed under another psychiatric category, such as manic depression or borderline personality disorder. Several recent surveys in the United States, Canada, and Europe have pointed out that as much as 1 percent of the population in the areas surveyed may have MPD to some degree.

It is hypothesized that most people with undiagnosed MPD go untreated and do not realize that they have the disorder. Frequently, people with undiagnosed MPD are aware of having some psychiatric symptoms (e.g., hearing voices or experiencing recurring periods of depression, mental confusion, or emotional ups and downs), but they seldom think of themselves as different from anyone else. They have lived most of their lives with these symptoms and have no idea what life without them would be like. Some multiples seek professional help because of psychological or physical symptoms, but it appears that a considerable number do not seek help out of fear of being considered "crazy."

THE MIND OF THE MULTIPLE

As a group, multiples are highly creative people with vivid imaginations and exceptional memories. Some even have what is known as a photographic memory: they are able to read a page in a book and retain the image of that page, so they can tell you where a particular sentence on the page is located

simply by recalling that image. It is surmised that by using their unusual powers of creativity and memory, multiples are able to construct imaginary personalities, remember in detail what those personalities are like, and then somehow assume those personalities.

A clue as to what might happen in multiples can be seen in the behavior of some small children who take on a new identity. For example, four-year-old Jennifer suddenly became Mary. When anyone addressed her as Jennifer, she would tell them that her name was Mary. Possibly, Jennifer did not like something about herself or her situation and preferred to be an imaginary person whom she liked or even admired. Somehow, in her own mind, she became that person. This process of identity change, which psychologists consider normal for a small child, could in certain individuals be the foundation for the later onset of MPD.

Many multiples have severe, persistent nightmares and, occasionally, daytime flashbacks. The nightmares of multiples are extremely disturbing, even terrifying; frequently, a multiple awakes from these dreams in a state of panic and later feels depressed and exhausted. The effects of these nightmares carry over into the person's daily life and can seriously hinder effective living and working. Once the multiple becomes fully involved in the process of psychotherapy, flashbacks of both nightmares and actual traumas become more pronounced and frequent; this can debilitate the multiple to the extent that he or she is unable to work for a time.

When a multiple has a flashback, he or she relives an event as if it were happening in the present. For instance, the multiple might revisit in his or her memory a particularly violent act of abuse that involved torture, or the brutal murder of a parent, as if it were happening right now. It is not usual for a multiple to take several days to recuperate from a flashback. Sometimes a multiple seeks pastoral counseling in a state of agitated depression after a particularly vivid flashback or series of flashbacks, yet he or she may not tell the counselor what happened.

Judy Kessler, coauthor of *The Family Inside: Working with the Multiple,* asked one of her patients to describe what it is like to have MPD. This was the patient's response:

> Walking on the edge of life, never knowing when you may appear in a place you know nothing about or how you got there; being called by a name that is not yours; voices, broken families, suicide attempts, confusion, incongruent feelings of laughter and depression; unspeakable nightmares; cold, chilling memories that don't belong to you; more voices, intense feelings of shame and guilt—this is what it is like to be a multiple. Life lacks continuity, strung along a time frame you have no control over; normal environmental stimuli are overwhelming, resulting in switching from personality to personality. And still there are the voices.

SIGNS OF DISORDER

Recognizing the presence of multiplicity can be extremely difficult, since multiples are adept at hiding their symptoms and concealing what is going on in their minds. It is not unusual for a psychotherapist to treat an individual with MPD for three or more years without realizing that the patient has that disorder. Without being aware of the inner torment of the multiple, some counselors or directors, viewing a multiple as normal and well functioning, may work with him or her as they would with any other counselee or directee, only to be baffled by a behavior or an emotional response they cannot understand.

There are, however, certain signs that may help a pastoral counselor or spiritual director detect—or at least suspect—the presence of MPD. If an individual complains of the following symptoms, the counselor would do well to consider them possible indications of MPD: persistent headaches, frequent spells of depression, emotional instability with outbursts of anger, memory lapses, inability to recall blocks of time, stormy interpersonal relationships, self-mutilation, suicidal ruminations, and impetuous, erratic behavior.

The multiple most likely to seek pastoral counseling is the one who is depressed and besieged with feelings of guilt, self-incrimination, and worthlessness. He or she may have had an angry encounter with a family member, friend, employer, or fellow worker. A multiple may complain about being treated unfairly or unjustly but will be vague and uncertain as to why he or she feels this way. As a consequence, the counselor is not quite sure what the individual's problem is or how to be of help.

A person with MPD will have memory lapses, during which he or she is unable to remember large blocks of time. These lapses occur when the multiple has switched from one alternate personality to another. When the second alternate takes over and becomes the host, that personality may have no memory of what the previous alternate did. Rather than reveal to the counselor that he or she does not remember what took place just prior to the matter under discussion, the multiple may invent a story about what he or she surmises to have occurred. Inconsistency, vagueness, and uncertainty in describing the details of past events can be indicators of MPD.

Still another sign is the frequent use of the pronoun *we* rather than *I*. Some authorities point out

that this usage is most common among multiples who have been in psychotherapy long enough to become acquainted with their alternate personalities. Individuals who do not realize that they are multiples are more apt to complain about demeaning and condemning voices in their heads. Usually, a multiple considers these negative, condemning voices to be his or her own (i.e., not one of the alternates') and becomes very upset by them. Sometimes the voices are perceived to be those of significant people in the multiple's life, such as a scolding mother or threatening older sibling who sexually abused the multiple.

Multiples suffer from amnesia. For example, a woman with MPD may find herself in a distant city and have no idea how she got there. While driving home, she may lose her way many times, because her new host alternate has no recollection of the route she traveled.

Also, multiples sometimes discover in their rooms clothes and other items they cannot remember buying or obtaining. The clothes or items were acquired by a previous alternate when it was the host and in control. Frequently, these items are not wanted by other alternates. For instance, a teenage alternate may buy summer clothes suitable for a high-school student, but an adult alternate that later takes control does not want to wear those clothes. Many multiples take a long time getting dressed because their clothes were purchased by previous alternates and the new host alternate does not like them.

Another sign that might cause the counselor to suspect multiplicity is a sudden and radical change in an individual's appearance and behavior, which may happen from one session to another or even within a single session. For example, one counselor who has done extensive work with multiples had an adult patient with MPD who at times not only acted like a small child, using language and a pitch of voice typical of a 6-year-old, but who also actually seemed to look like a child at those times.

Some multiples who seek pastoral counseling may display cuts or burns on their arms or legs, or they may hint at or openly express suicidal intentions. These signs of possible multiplicity should be taken seriously, and a referral to a psychiatrist or psychologist should be made.

Some multiples have a "persecutor" alternate that is bent on harassing or even destroying the multiple, as well as all the other alternate personalities. The persecutor alternate insists that the multiple is to blame for all that has happened to himself or herself, and may repeatedly urge the multiple to cut his or her arm or leg with a razor blade or even commit suicide.

COUNSELING MULTIPLES

When multiples have a problem that relates to their religious beliefs or practices, or want to discuss their spiritual life with a knowledgeable person, they sometimes seek out a pastoral counselor or spiritual director. Usually, these multiples are (1) people who do not realize they have a disorder, (2) people who believe they have other psychological disabilities but actually have MPD, or (3) people who are in treatment and have a pastoral or spiritual issue they wish to discuss. In addition to needing pastoral counseling and spiritual direction, the first two categories of multiples need prolonged, intensive psychotherapy with a psychologist or psychiatrist who has had training and experience in treating people with MPD. The kind of treatment they need is beyond the expertise and time limitations of pastoral counselors or spiritual directors. Ideally, psychotherapy for MPD involves sessions of one to two hours in duration, two or three times a week, for four or five years.

In attempting to help an individual with MPD (diagnosed or not), counselors and directors should remember that they are usually dealing with one personality at a time and should try to help that personality—whether the core one or an alternate—solve the problem it presents in a given session. The same problem may or may not affect the other personalities, depending on whether or not they have any contact with the alternate in control.

Because a switching of personalities can take place between sessions, counselors should not expect that a multiple will necessarily remember what took place in a prior session, even if a crucial decision was made. Often, it is only after a couple of years of psychotherapy that a multiple's alternate personalities learn of each other's existence or have any contact with each other. Within one individual with MPD, it is possible that some alternates are in touch with the experience of others, whereas some are totally dissociated from the other alternates. Consequently, during a given counseling session, the multiple may be unaware of problems discussed at a previous session, may serve as a poor informant, and may offer vague, incomplete, or baffling information when interviewed. The counselor may have to repeat the same questions asked at a previous session to obtain necessary information, which may differ from previous information. The counselor should be aware that in order to save face, some multiples act as if they remember past sessions when they actually do not. Multiples tend to be adept at hiding their amnesia.

Each alternate has its own distinct view of the world, which often includes religious views and beliefs. One alternate may have a devout belief in Christ

and the Christian message, while another may seem to reject much of Christianity or express hostility and antagonism toward religion. One alternate's concept of God or moral standards may be quite different from that of another alternate. Depending on what is discussed during a session, the counselor may or may not notice a marked change in the counselee's attitudes.

AVOIDING NEGATIVITY

In dealing with multiples, counselors and spiritual directors should make an extra effort to be positive, supportive, affirming, and encouraging, especially if the multiple is anxious, agitated, or depressed. Being supportive calls for the counselor to be respectful of the multiple's views and feelings at all times, even when he or she is not respectful toward the counselor or expresses negative attitudes toward the church and its teachings. Rather than take personally what the multiple says, the counselor must keep in mind that the alternate in control is expressing its views and feelings, which may or may not be the views of the core personality or the other alternates. Most multiples are already "down" on themselves; expressions of criticism or reprehension from others only worsen their already low self-esteem, make them feel more guilty, and decrease their self-confidence. Occasionally, negative criticism can even cause a multiple to switch to an alternate personality that is more aggressive and hostile—and less likely to benefit from counseling or direction.

Research indicates that many multiples have a "troublemaker" alternate that is a disruptive force both within the multiple and in the multiple's dealings with the external world. Occasionally, this alternate shows up for a pastoral counseling session and tries to antagonize and undermine the counselor. Sometimes the troublemaker waits for the counselor to take a stand and then attacks that stand. When this happens, the counselor must recognize what is happening and not allow himself or herself to be drawn into a trap.

BEING LIKE A FRIEND

The best tack that a counselor or director can take with a multiple is to be like a friend who has genuine concern for the multiple and cares about him or her as a person. Many multiples have had highly emotional and damaging disagreements with family members, relatives, and/or friends. In some cases a family member or other relative has abused the multiple, and the other relatives either have refused to believe this fact, siding with the abuser, or have minimized the abuse and urge the multiple to forget the whole affair, which is very difficult to do, considering the damage done. Because of such problems, some multiples cut themselves off from their families and friends, feel very much alone in what they see as a hostile world, and are in great need of someone who can show understanding and concern for them.

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Unfit to Minister

Len Sperry, M.D., Ph.D.

Religious superiors, diocesan officials, and pastors are often charged with the difficult task of determining whether or not a given individual is fit for active ministry. The decision may be rather straightforward in certain instances—for example, when an individual is convicted of pedophilia. But in other cases the decision may be quite complex and difficult, especially when ministry unfitness is confused with ministry impairment. What criteria determine fitness or unfitness? Which of the following ministers would you assess as being unfit for ministry?

THREE MINISTRY EXAMPLES

The first case involves an associate pastor who was arrested for driving under the influence of alcohol. A short account of the incident appeared in the daily newspaper. A week prior to the arrest, the rectory housekeeper had observed what she described as slurred speech. While in an alcohol detoxification program, the priest was diagnosed as clinically depressed (secondary to the death of his younger brother) and was prescribed an antidepressant medication. No prior history of substance abuse or serious ministry problems was found. After a four-week hospitalization, he was discharged.

The second example involves a lay music minister in a large urban parish—a man with a reputation for being colorful and offbeat. While endearing to some, his dramatic flair was upsetting to others, who contended that his eucharistic liturgies were essentially musical performances rather than occasions of worship. The minister downplayed allegations that he engaged in liaisons with married female parishioners. Complaints that he was self-absorbed, demanding, indifferent to others' needs, and noncompliant with the pastor's directives and limit setting were also lodged. Nevertheless, the pastor enjoyed the type of liturgical music the minister played and was reluctant to support the parish council's plan to not renew the minister's contract.

The third case involves a nun who was diocesan coordinator of Rite of Christian Initiation of Adults (RCIA) programs. Although she possessed excellent credentials, her performance had not matched her promise. She was absent or late for appointments and inconsistent in the supervision of her staff, and she had failed to respond to her boss's coaching on handling personnel matters. She reportedly lost her temper and cried over minor interpersonal slights. At a budget meeting she raised eyebrows by screaming that if the bishop and chancellor really cared about her or RCIA candidates, they would not cut her

budget. Her personal life was reported to be chaotic, and her associates wondered if the scars on her wrists represented suicide gestures.

At first glance, it might seem that the priest with the newspaper-reported drinking problem and arrest would be unfit for ministry, whereas the music minister and RCIA coordinator, although troublesome, would probably be fit for ministry—although perhaps not in the jobs described. A judgment that the priest was unfit would probably be based solely on the criterion of public scandal. But there are problems with the use of a single criterion such as scandal. For instance, a priest's intoxication may not raise eyebrows in one community, whereas it may ignite a firestorm in another. Furthermore, what constitutes scandal for a child is likely to be different from what constitutes scandal for an adult. For this reason, additional criteria are useful in determining whether or not an individual is fit to engage in active ministry.

MORAL, SPIRITUAL, AND PSYCHOLOGICAL IDEALS

Such criteria as honesty, integrity, self-surrender, and transparency of character reflect basic moral, spiritual, and psychological ideals deemed essential to Christian ministry. It is presumed that the more the minister strives after these ideals, the more likely it is that he or she will function as a credible and effective witness of the gospel, and vice versa. Thus, a ministry based on honesty and integrity is preferable to one based on dishonesty, misrepresentation, pretense, and lack of integrity. Furthermore, a ministry centered on the Lord and characterized by self-surrender and generosity is preferable to one based on self-aggrandizement and self-serving actions. Similarly, a minister who strives to be transparent and genuine in dealing with others is preferable to one who is opaque or plays games. There are no surprises with transparent ministers; they are who they represent themselves to be. On the other hand, there are surprises with ministers with opaque characters, who often lead double lives. For instance, in time it may come to light that an associate pastor or music minister who has been so enthusiastic about youth ministry is actually a sex offender.

Corresponding to these moral and spiritual ideals are certain psychological features. The more ministers strive toward these moral and spiritual ideals, the more likely they are to be helpful and collaborative, forgiving and conciliatory, empathic and compassionate. Furthermore, they are less likely to be self-absorbed and self-serving, to demand to be the center of attention, to control and manipulate others, to seek revenge, and to be indifferent to others' needs.

For the most part, severe personality disorders—particularly the reactive, or malignant, narcissistic personality disorder—reflect the "unfit for ministry" indicators and their corresponding psychological features.

CRITERIA FOR MINISTRY UNFITNESS

The following six criteria are useful in discerning whether an individual is unfit to engage in active ministry. These criteria involve observable maladaptive behaviors and are psychologically based; they also reflect a lack of the basic moral and spiritual ideal of honesty, integrity, and compassion in ministry. The first of the six criteria is the basic criterion, and the others may be considered supportive criteria.

1. A consistent pattern of opaqueness of character, lack of integrity, dishonesty, and self-serving actions. Such a pattern usually characterizes a severe personality disorder (e.g., narcissistic, antisocial, borderline, or paranoid personality disorder). The presence of such other disorders as major depression, bipolar disorder (manic depression), obsessive-compulsive disorder, or panic disorder in the *absence* of a severe personality disorder does not necessarily indicate unfitness for ministry. On the other hand, psychiatric disorders that severely limit an individual's ability to remain in contact with reality or to relate to others (e.g., schizophrenia, delusional disorder, dissociative disorder, severe obsessive-compulsive disorder, or a chronic incapacitating substance dependence) might render an individual unfit for active ministry.
2. Unwillingness to participate or unresponsiveness to coaching, spiritual direction, limit setting, or other efforts to change or ameliorate the maladaptive pattern.
3. Refusal to comply with a referral for psychiatric treatment (e.g., inpatient or residential treatment, medication evaluation, or individual or group therapy) or failure to meet treatment goals and improve sufficiently.
4. Criminal behavior, whether or not it results in criminal charges and conviction, or severe problems with authority (e.g., continued defiance or rule breaking).
5. Presence of a substance addiction, relationship addiction, or behavioral addiction (e.g., gambling).
6. Significant concern about the impact of the individual minister's behavior or about a career history marked either by inconsistency or by negative effects on the spiritual and psychological well-being of others through poor performance in ministerial duties (e.g., spreading harmful rumors;

being physically, verbally, or emotionally abusive; being chronically late or absent from assignments; being the source of scandal).

Generally speaking, the first criterion plus one or more of the supporting criteria are strongly suggestive of unfitness for ministry. Two exceptions are noted: (1) if the individual does not meet all the criteria in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition *(DSM-IV)* for a severe personality disorder, then three or more of the supportive criteria of unfitness should be present; and (2) a single criterion, such as admission of guilt and/or conviction of a felony offense such as homicide or pedophilia, is probably indicative of unfitness. On the other hand, arrest and conviction for driving under the influence of alcohol without the presence of a severe personality disorder or another of the above criteria does not necessarily suggest unfitness.

MINISTRY IMPAIRMENT VS. UNFITNESS

A basic psychological tenet is that personality and character are stable and relatively impervious to change. Unfortunately, this means that the prognosis for most, if not all, individuals who are determined to be unfit for ministry by the above criteria is very guarded. Unfitness must be distinguished from impairment because there is some overlap between the two.

Generally speaking, impairment involves a serious medical or psychiatric condition that greatly reduces or prevents an individual from performing most or all of his or her ministerial functions. On the other hand, someone who may be unfit to minister can often perform aspects of his or her ministry functions well enough to avoid early detection.

Impairments are potentially treatable and may be curable. For instance, many common disorders (e.g., depression, bipolar disorder, anxiety disorders, alcohol abuse) are very amenable to psychiatric treatment and have fair to good prognoses. In contrast, severe personality disorders are much less amenable to treatment and thus have poor prognoses. Personality disorders may be present in some, but not all, impaired ministers (therefore, it is conceivable, though rare, that a minister can be both impaired and unfit for ministry). On the other hand, severe personality disorders are almost always present in unfit ministers. Accordingly, the prognosis for individuals deemed unfit for ministry is very guarded or poor—and, unfortunately, this effectively limits their options. Often, in order to reduce chaos or unrest in a religious community, parish, or diocesan office, as well as to reduce legal liability, many (if not most) unfit individuals are removed from active ministry.

MINISTRY EXAMPLES REVISITED

Returning to the three cases outlined earlier, it should now be apparent that the priest arrested for driving under the influence of alcohol would not meet the criteria for ministry unfitness. Although there is evidence of Axis I disorders (major depression and alcohol abuse), there is no indication of a severe Axis II personality disorder, or refusal to comply with treatment or limit setting, or obvious scandal—only the housekeeper had witnessed the individual's slurred speech on a single occasion. Because no mention is made of the priest's failure to function ministerially, it is also unlikely that impairment is present.

While the other two cases might appear to be less serious, reviewing them in light of the proposed criteria suggests that they are serious indeed. In fact, both individuals meet criteria for ministry unfitness. The music minister, who has a narcissistic personality disorder with antisocial or psychopathic features, meets four of the six criteria (see my article "The Narcissistic Minister" [HUMAN DEVELOPMENT, Fall 1995] for a description of the reactive, or malignant, narcissistic personality, which he exemplifies). His defiance of the pastor's authority, his unresponsiveness to the pastor's limit setting, and the presence of significant concerns about the impact of his behavior on parishioners (e.g., his alleged liaisons with women), as well as his empathic deficits, suggest that he is probably unfit for any active ministry. Similarly, the nun seems to meet three of the five criteria for unfitness. First, she apparently has borderline personality disorder, one of the most severe and difficult-to-treat Axis II disorders. Additional criteria include unresponsiveness to coaching provided by her boss and significant inconsistency in her job performance.

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Individual Growth Within a System

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All of us exist within systems composed of people: those with whom we live, work, and play. We are born into a family; we choose friends. Some of us have a gregarious lifestyle, some a solitary one. The lifetime struggle to understand ourselves requires efforts to see our systems more clearly.

In working with men and women in religious communities, I have discovered that in the past, many were required to keep silent about their personal histories. In an attempt to create equality among membership, their communities forbade the sharing of family stories. But how do we learn of ourselves and others, develop balance and harmony in our lives, or grow in psychological health without being aware of and sharing bits of our pasts?

CONNECTION FOSTERS GROWTH

In *Women Who Run with Wolves*, Clarissa Pinkola Estes describes her dream of storytelling. She experiences herself standing on the shoulder of an older woman, who is patting her foot in encouragement. Horrified, Estes says that she should be supporting the older woman, not vice versa. But the dream woman says no, this is how it is done. She points out to Estes that she herself stands on another, even older woman's shoulder, and that woman stands on another's, who stands on another's, into antiquity.

Our histories are valuable supports—critical components of a stable structure. In the current rage to reengineer the business world, corporate consultants stress the need for maintaining some connection to the past. As divergent groups integrate into huge networks, the people involved must tell stories to one another to achieve a successful flow. Similarly, therapists encourage blended families to share rituals and learn where each member has been in order to move into the future.

I use the term *stories* because absolute truth and correct detail are far less significant than the sharing of impressions, feelings, and beliefs about ourselves. When a bald eagle couple finds a safe nesting site, they return year after year, adding nesting material to the base. Likewise, human beings build on a base of culture, religion, memories, and myths—the feathers, twigs, and grasses of an ancestral nest.

The relational model of human development tells us how critical it is to value the context of our connections. Complex and varied, this matrix of our existence evolves continuously across time and space. We learn through authentic interactions within relationships. When we attempt to cut off or deny parts of ourselves, we exclude those aspects of ourselves

from the potential for change. In an article entitled "A Relational Approach to Understanding Women's Lives and Problems" (*Psychiatric Annals*, August 1993), Jean Baker Miller and Irene Pierce Stiver write that "the interchange within connections [is] precisely the source of knowledge and clarity needed for the development of an increasingly accurate image of self and others." This interchange is the avenue of growth for the individual, which is essential to the health and growth of the system.

PAST MUST BE EMBRACED

As a mental health clinician, I feel heartache for individuals who attempt to cut off or deny their past in order to protect or heal—as if a plant can survive without roots. A delicate bonsai will thrive with attention and appropriate trimming of roots but will wither and die without them. At times, we all need to soothe ourselves quietly in privacy. We may sometimes experience being soothed in the company of another. The word *soothe* originates from Middle English and relates to truth: we cannot be soothed without authenticity.

No one can demand that we always share of ourselves; nor would it be healthy to always and everywhere anticipate that someone will express interest in everything in our internal stream of consciousness. This style of narcissistic preoccupation can be destructive to individual and system alike. The pain I experience as a therapist is for those unable or unwilling to trust that the world is safe enough to share their vulnerabilities.

Sometimes great pain and sorrow are found in the stories of our past. Many of us have experienced trauma, some severe; none of us has passed through unscathed. We have body memories of abandonment and rejection. We feel shame, guilt. We know the suffering of loss. All of us carry memories of deep wounds. How can they be embraced into our healthy present? By speaking of painful pasts, giving words to profound hurts, and exposing buried horrors to the light of another's acceptance, we can decrease their powerful grip. We can be trapped in dank, dark, lonely prisons of our own making when we clutch past pain tightly. Beginning to let go takes great courage, but the rewards can be amazing.

CHANGE INEVITABLE

Things change. What we know, believe, and value at age 20 and at age 40 may be quite different. Our systems change around us. We lose some loved ones to death and gain new ones through birth. We move; others move. Rules change. My church once told me not to eat meat on Friday; I recall my experience of a painful struggle years ago, as an 8-year-old, over a bowl of chili con carne at my Protestant neighbors' dinner table one snowy December Friday. I may offer myself bemused comfort from my adult vantage point over this incident, but the pain was/is real.

Some religious communities formerly had very strict rules limiting family visits. Today, in response to a parent's illness, a vowed man or woman may take leave to be at the parent's bedside. Years ago, this might not have been permitted. Deep pain, smoldering resentment, profound guilt may be felt around losing such an opportunity forever—to be with a parent at the time of death. Speak it; share it; see it in the light of compassion. We are all doing the best we can, given what we have, know, understand, believe, and value, in any given time and space.

RISK ESSENTIAL TO UNDERSTANDING

In sharing, we find similarities that join us and differences that add to the richness of our lives. Carole King's song "Tapestry" describes the psychological wealth available through connection: "My life has been a tapestry of rich and royal hue, / and everlasting vision of the ever-changing view, / a wondrous woven magic in bits of blue and gold, / a tapestry to feel and see, impossible to hold." Each of us possesses a tapestry, the developing pattern of which is continuously revealed. Your vision of mine may open you to a worldview unseen before, and my vision of yours offers me the same possibility. This potential for growth and change is wonderful and terrifying. Some individuals may be unable to respond to the offer, for the risk is great: people may laugh, or not listen, or not understand, or assume they understand when they haven't really heard. You may open yourself to share with someone who does not reciprocate. I may share my prized treasure of a childhood memory, and you may see it as a fleck of dust. My story may dull in the shadow of yours. Risk? Yes. But if our goal is psychological health and personal understanding and growth within our chosen systems, we must tell our stories and hear those of others.

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Medical Cost Conservation in Religious Congregations

Richard P. Johnson, Ph.D., and
Mary Roman Adam, S.S.N.D.

Religious congregations that have opted for self-insured status need to act on their decision by functioning like health maintenance organizations (HMOs)—that is, by adopting the general operating principles and policies that have proved so successful for HMOs. Congregational leadership teams need to move quickly in this regard.

The medical community is in a great state of flux. Change seems to be pummeling this monolith of cultural compassion from every point possible. On the technical front, new drugs, procedures, evaluation devices, rehabilitation processes, and therapies continue to roll off the medical research assembly line. Competition among health care providers has reached frantic and sometimes confusing levels. Restructuring, reorganization, downsizing, hospital closures, and "merger mania" buffet the governance of the system daily. Government regulations seek ever-expanded services for ever-shrinking reimbursements.

Medical care providers—doctors, nurses, and an army of ancillary lab technicians, technical services personnel, and therapists—feel mounting frustration caused by a multilayered bureaucratic labyrinth that demands increased scrutiny and an avalanche of new forms to ensure procedural accountability. All this takes place in the context of a cultural mentality that drives a torrent of litigation, both credible and otherwise, putting added distress on a system already oversaturated with change.

SELF-INSURED RELIGIOUS CONGREGATIONS

Into this confoundingly new medical landscape comes the religious congregation, buoyed by its newly passed self-insurance decision and glad to be free of taxing medical insurance payments. The congregation is trepid but hopeful that this new arrangement can better serve both the financial realities and the medical needs of its members.

Currently, many changes in the medical community itself, as well as related changes in religious congregations, are the result of the rising popularity of the HMO. An HMO is basically a medical payment broker that positions itself between a defined group of people, called the members, and the medical community. The HMO operates by offering subscriptions for medical care to groups of individuals, usually through their employers. The HMO surveys the medical services available in its locale and develops contractual agreements between medical service providers and itself as the representative of its members. Fundamentally an entrepreneurial, for-profit enterprise, the HMO seeks to conserve its financial resources, received through monthly membership

subscription fees. It achieves profitability in a number of ways:

Negotiated agreements for discounted fees. The HMO is a discount shopper and will seek to pay the lowest possible fee for any given medical service. For example, if the "normal" fee for an appendectomy is X, the HMO will negotiate with a hospital for a price that is some fraction of X (perhaps two-thirds or three-quarters).

Identification of primary care physicians. Each HMO member must select a primary care physician (i.e., a family physician, an internist, a pediatrician, perhaps in some cases an obstetrician-gynecologist). The primary care physician is the gatekeeper for entry into any specialized care. When an HMO member wishes to see a medical specialist, he or she must go to the primary care physician and receive a written referral, which must be cleared by the HMO. Essentially, the referral by the primary care physician is a request for service to the HMO and certifies that the visit to the specialist is a medical necessity.

Care limits. The HMO specifies exactly what medical services it will imburse, and in what amount. All other services, including services beyond established limits, are declared "out-of-plan" and are nonimbursed. For example, the HMO may determine that it will imburse up to twenty psychotherapy visits per year per member, or fifteen chiropractic sessions per year, or one dental cleaning per year. Any services beyond these limits are the financial responsibility of the care provider, the member, or both.

Care clearance. HMOs often impose on care providers the responsibility for justifying their care plans in writing to the HMO. For example, a psychotherapist must submit a written request to be granted a specific number of visits with an individual patient who has been referred by his or her primary care physician. The request must include the diagnosis, the type of therapy recommended, the number of visits required to address the problem, the expected outcome of the proposed treatment, and the time frame within which the treatment will take place.

When the care provider's written request is received by the HMO, its staff evaluates the credibility and efficacy of the request and makes an imbursement authorization decision accordingly. Any treatment that is given by a care provider before the HMO authorization is given, and/or is not strictly in keeping with the specifications, limits, and time constraints of the HMO authorization, is automatically considered "out-of-plan" and goes unimbursed.

Member education. The HMO continuously endeavors to provide educational opportunities for its members. Such patient education falls into two categories: (1) education regarding health and wellness self-management skills, knowledge, and behaviors, and (2) education designed to make the member a more informed medical care consumer. The type, quality, and mix of educational programs offered by HMOs varies greatly.

These are the general principles and policies under which most HMOs operate. Naturally, differences are found among the many HMO plans that exist. Competition for members is keen, so various selling points are devised by each HMO to set it apart from others. It has taken some years for the HMO movement to be fully accepted into the medical imbursement schema, but there is now no doubt that the concept is here to stay and is growing at an ever-quickening pace.

ACT LIKE AN HMO

The religious congregation needs to act like an HMO for two reasons. First, medical care is a major operating expense for any congregation. The graying of congregations has served to drive up medical care costs exponentially, and many religious congregations anticipate eventual financial insolvency as a result. The most nettlesome problem faced by a congregation is the members' freedom to seek medical care from any care provider on any schedule and for any duration. Few religious congregations impose restrictions on medical care procurement at the member level, even though no such freedom of action is allowed on any other line item in the congregational budget. Essentially, every member of the congregation is a medical care purchasing agent—a representative of the organization, fully capable of incurring debt on the congregation at his or her whim. The congregation is thus financially held hostage to the medical care procurement decisions of its individual members.

An even more compelling reason for a congregation to adopt HMO-like principles and policies is to ensure good medical care.

Good medical care is measured not by the amount of medical services an individual receives but by the quality of the care received. Quality care is an elusive notion. The same care that in one context is seen as quality care may, in another context, be viewed as capricious, unnecessary, extravagant, nonessential, defensive (i.e., litigation-conscious), or even harmful.

When a patient sees the same physician over the long term, the mutual knowledge that develops promotes prudent, effective, and quality medical care

Quality primary medical care is generally seen as fulfilling two criteria: it must be comprehensive, and it must be continuous. Comprehensiveness demands that medical care be thorough rather than piecemeal, whole rather than partial, complete rather than simply cursory, integrated rather than fragmented. Comprehensive medical care is inclusive rather than exclusive; it looks at the person as something more than the sum of his or her component parts. Continuous medical care means that the same hands of caregiving touch you, the same eyes see you, the same voice speaks to you on a longitudinal basis. When a patient sees the same physician over the long term, the mutual knowledge that develops promotes prudent, effective, and quality medical care.

Comprehensive and continuous care is rendered best by a primary care physician who can advise, counsel, listen, and empathize. The patient is afforded the benefit of being known as a person as well as a patient. This is the ideal doctor-patient relationship—one that breeds trust, confidence, and hope, all necessary ingredients for healing. The goal of the pure HMO is the creation of a forum in which intelligent care options can be entertained, chosen, and executed. If the patient needs more specialized services than the primary care physician can provide, an appropriate referral is made without hesitation by the primary care physician.

Certainly, no medical care is given with the intention to harm; clearly, however, harmful care is nonetheless given unknowingly at times. When a member of a congregation consults a specialist and, for one reason or another, does not fully inform the specialist of previous treatment or current therapies and medications, the specialist is at risk of violating principles of good medical care. He or she may order redundant tests and examinations, give advice contradictory to that of another physician who had the benefit of knowing the patient's full medical history, or prescribe medications that pose an increased risk of harmful side effects or interactions with other medications.

Often, tests and examinations are ordered by conscientious physicians who make their decisions based on simple conformity to established standards of care. Such motivation for ordering tests, and consequently for spending congregational funds, may or may not meet standards of efficacy (e.g., are the tests genuinely required in the sense that their results might alter the treatment outcome in a positive way?). HMOs find ways of modifying the test-ordering behavior of physicians by including the costs of tests ordered into an overall equation used to determine individual physician remuneration, or capitation (the amount received by the physician each month from the HMO). If the physician exceeds certain established guidelines set by the HMO, compensation to the physician is reduced. Congregations that self-insure need to establish similar guidelines for physicians who care for their members.

This is not to imply that medical care cost-conservation techniques begin and end with the physician; far from it. Indeed, the first step is for congregational leadership teams to educate themselves about the workings of HMOs and to seek ways and means of adopting selected HMO procedures in their own congregations. The second step is to develop an educational plan for informing congregational members of the new realities of the congregational medical care cost-conservation program. Some members will undoubtedly interpret the new HMO-like policies as misguided, heavy-handed, unnecessary, un-Christian, draconian, or even barbaric. Continuous education, together with accountability procedures at the individual level and a program of incentives for participation in the conservation thrust, will eventually pay off in resources saved and improvement of the overall quality of medical care received. It is advisable for the congregation to publish a "Rights and Obligations Policy" regarding the new approach to medical care.

SAMPLE RIGHTS AND OBLIGATIONS POLICY

Every member has the right to:

1. Obtain quality essential medical care.
2. Have his or her own primary care physician.
3. Question his or her medical care providers about procedures, practices, medications, and whether any recommended treatment is essential.

Every member has the obligation to:

1. Continuously and conservatively monitor his or her own medical care costs.
2. Learn as much as possible about the medical care system and how to use it most efficiently.
3. Practice self-care techniques and principles on a regular basis.
4. Always consult his or her primary care physician before making major care decisions.
5. Understand that medical care is exhaustible.
6. Weigh the need for services against the desire for services.
7. Seek the lowest fees for any medical service.

Some members may, through guilt or false humility, neglect legitimate medical care needs for fear of upsetting leadership or placing an unnecessary financial burden on the congregation. Assurances need to be made that all essential medical care needs will be honored without question or adverse consequence. Such a policy may be more easily articulated than executed. Nonetheless, congregations need to move in this direction.

Reeducating members about the requirements of eliminating nonessential medical care is a challenge; controversy and potential conflict may emerge. For this reason, we recommend hiring an outside person to act as coordinator of medical care procurement—that is, to serve as a purchasing agent for medical services. The coordinator would become intimately aware of the medical care needs, both preventive and acute, within the congregation, and serve as the liaison between individual members and health care providers. He or she would be responsible for upgrading the overall health and wellness of congregational membership while at the same time putting in place HMO-like policies and procedures. The coordinator's salary would be made up many times over by the savings realized through good care-conservation measures.

One model that approaches the recommendations described here is the COMED model sponsored by the Dominicans of Sinsinawa, Wisconsin, and the Franciscans of Dubuque, Iowa.

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Magdalen Coughlin, C.S.J. 1930–1994

Carol Anne O'Marie, C.S.J.

When Sister Magdalen Coughlin died, less than two months after her 64th birthday, she was honored by the Los Angeles City Council and the California State Assembly. The *Los Angeles Times* published a two-column obituary.

Her funeral service overflowed with church and civil dignitaries; movie personalities; students, past and present, from Mount Saint Mary's College in Los Angeles, where she served for nearly twenty years; members of her family and of her community; childhood friends; and the college's domestic staff. Cardinal Roger Mahoney, archbishop of Los Angeles, praised her as "one of the most important leaders of the church and its many apostolates in Southern California in modern times."

Although we were aware of her giftedness, those of us who knew her well thought of Magdalen primarily as a dear and good friend. Perhaps her greatest gift was her ability not only to make friends but also to keep them. Despite her demanding schedule, Magdalen always found time to listen, laugh, and celebrate. She seemed happiest when watching everyone laugh and talk and have a good time at parties she engineered for her fellow sisters. "Isn't it fun to be a nun?" she'd say, and she genuinely meant it.

Even after a full day or a busy week, Magdalen thought nothing of driving for several hours to meet with friends and "talk a few things over" at dinner. When those of us less hardy asked "Should we?" her answer was always "Why not? Life is too short."

How was a woman of such renown able to remain so real? It may well have begun in Wenatchee, Washington, where she was born on April 16, 1930. The second of four children and the only daughter of William Coughlin and Cecilia Diffley, she was christened Patricia Louise.

Her mother was a spicy Irishwoman who liked a good joke, a good party, and a good drink—and whose faith was strong and practical and real. Her father was a Wisconsin farm boy who had come West with the railroad. Though less formally educated than his wife, he was extremely well read and had a great interest in politics. Magdalen lived her whole life close to the inheritance she received from them. She often joked that she grew up never being sure which was most important: being Irish, being Catholic, or being a Democrat.

In Wenatchee, working side-by-side with the apple pickers at Skokum Packing Company, Magdalen developed great respect and reverence for every person—qualities that were to characterize her life. It was while working at Skokum's that she received notice that she had been chosen as a Fulbright scholar.

From the time she was a child, Magdalen wanted to be a nun. Only God knows where the idea originated.

There was no Catholic school in Wenatchee, an anti-Catholic town where crosses burned at night in the hills. She had never been around nuns. In fact, she never even had a Catholic friend until she went away to college. Her father wisely suggested that she attend the College of Saint Catherine in Saint Paul, Minnesota, to find out what being a sister was all about.

At Saint Catherine's she pursued knowledge with the wholeheartedness that was so characteristic of her. There her faith was formalized and her love of learning fed. When she graduated, her scholarship took her to the Catholic University of Nijmegen, in the Netherlands.

In 1957, with her parents' permission to be free, to go, to do, she brought all her openness, enthusiasm, and other gifts to the Sisters of Saint Joseph of Carondelet. During her thirty-seven years in that congregation, she deepened her friendship with God and always did what she thought was God's will. She studied, earned a Ph.D., became regional superior and councilor, and accepted the presidency of Mount Saint Mary's College, and later its chancellorship—although her preference had always been to teach.

With her clear, concise vision of what is good and what is true, she served as the moral conscience of the many organizations to which she belonged, urging them with humor and gentleness to work for the common good. "The world is waiting for the sunrise," Magdalen often said, and she herself did not shrink from the challenge. No dream was ever too big or too insignificant.

In all she did, she was open and nonjudgmental. She had no time for anything petty. She had a knack for bringing out the best in others and treated every person she met, from the smallest child to the most renowned dignitary, with the same reverence and care.

During the final months of her battle with cancer, she received literally thousands of letters of encouragement, tributes from friends in every walk of life—people she had touched with her goodness. Even in the face of this outpouring of adulation, she remained unimpressed by her own accomplishments.

"Life is too short," was one of Magdalen's catchphrases. Her own life was truly too short for those of us who called her "friend." As the poet Maya Angelou so beautifully expressed it in a telegram of condolence, "We all have been lessened by her passing and yet enriched by her living."

Sister Carol Anne O'Marie, C.S.J., is codirector of A Friendly Place, a daytime drop-in center for homeless women in downtown Oakland, California. She is also the author of the Sister Mary Helen mysteries.

New Understanding and Treatment of Ulcers

Most people who suffer from ulcers in the lining of the stomach or small intestine blame either the stress in their life or spicy foods in their diet. A recent survey conducted by the American Digestive Health Foundation showed that 90 percent of ulcer sufferers cite stress and 60 percent of them identify diet as the source of the painful sores in their digestive tract.

New research, however, has found that contrary to popular belief, fully 80 to 90 percent of this misery is due to a bacterial infection caused by an organism known as Helicobacter pylori (H. pylori). This discovery suggests a radically different medical treatment for the 25 million Americans who suffer from ulcers and have been taking antacids in hope that they will cure. The currently recommended therapy involves a course of treatment with an antibiotic (or two), along with bismuth or antacid drugs known as H2 blockers.

Unfortunately, doctors are finding that their patients are slow to adopt and comply with the necessary antibiotic treatment. They warn that patients who begin but don't fully complete this treatment are likely to experience recurring ulcers and may cause the bacteria to become resistant.

In the United States, nearly half a million new ulcer cases are diagnosed each year. Among the four million patients with chronic disease, about a million are hospitalized for complications such as bleeding or perforation. In developed countries, as many as 60 percent of adults are infected with H. pylori; in developing countries, 80 percent carry the organism.

Religious Formation in a Setting of Violence

Annmarie Sanders, I.H.M.

Alicia, a 24-year-old novice, sits down with her formation director to discuss a concern. The parish youth group adviser in one of the poorest shantytowns in Lima, Peru, Alicia is preparing a talk for thirty young adults. She wants to present a series of steps for nonviolent approaches to conflict resolution. She is, however, afraid.

Alicia suspects that two of the youth group members who plan to attend her talk are members of Sendero Luminoso (SL), Peru's savage and secret revolutionary group. SL preaches that armed conflict is necessary in the Peruvian class struggle. Alicia is in a quandary: She wants to help the youth with nonviolent conflict resolution, but at the same time she knows that SL has killed church members who promote peace by speaking against armed conflict.

FORMATION AMID UNREST

Alicia's dilemma and the challenge she presents to her director point to some of the questions facing those currently working in formation programs in Peru. Throughout that country, religious congregations are trying to provide realistic, adequate formation programs in the midst of what some term "a revolution waiting to happen." Such issues as living with fear, maintaining hope, and coping with the possibility of one's own death must be included in our programs of formation because we are preparing our future members to work as church leaders in a society immersed in violence and instability.

Peru is a country that cries out for peace and security. Despite the recent arrests of their top leaders, terrorists (members of SL and of the Tupac Amaru Revolutionary Movement) continue their armed and bloody struggle. More than 25,000 deaths have resulted from political violence since SL launched its "People's War" in 1980. The fight against terrorism is being led by the equally brutal Peruvian armed forces, which have been accused of serious human rights abuses and among which there is great unrest. On top of all this, Peru is battling one of the most serious drug-trafficking problems in the world.

A deep recession also plagues the Peruvian population, despite claims by some analysts that the country's inflation rate has vastly improved. Approximately 60 percent of Peru's citizens live in extreme poverty, and a high percentage of the working population is underemployed.

In the face of the economic crisis, political violence, and rampant governmental corruption, Peru's current president, Alberto Fujimori (elected in 1990) surprised the world in April 1992 by dissolving the national congress, suspending parts of

the constitution, and instituting press censorship. Most Peruvians applauded the president's actions. Now the country is supposedly in the process of restoring democratic rule. Many wonder, however, if Fujimori is just another dictator, hiding behind a veil of democracy.

The task facing religious congregations in Peru is to understand the makeup of young women and men who have lived in this unstable and violent reality and now want to commit themselves to a vowed life within the community. The task is complicated by a centuries-old struggle among the various peoples of Peru's coast, jungle, and sierra, who see themselves as persons of three separate cultures. Besides understanding how Peru's current reality affects its population in general, congregations must also study its unique effects on each of those cultures.

FEAR AND DISTRUST RAMPANT

Studies have examined the emotions and reactions experienced by people living in unstable areas, especially those most strongly affected by violence and poverty.

People living in regions marked by terrorism or in areas taken over by the armed forces as operation centers, as well as individuals fleeing their homelands to escape terrorist threats or assassination attempts, commonly experience such emotions as anger, fear, impotence, rage, and discouragement. Many claim to feel a loss of control and an inability to prevent what seems to be inevitable. People living under the threat of death or those who have been displaced from their homelands often feel it is too dangerous to participate in society, express themselves publicly, or organize.

Distrust is a common feeling experienced by those living among terrorism. The belief that "the party [SL] has a thousand eyes and a thousand ears" is strong, and many feel that their actions are being watched. People often fear talking to individuals whose backgrounds they do not know. Some individuals are automatically suspected of terrorism because they come from the jungle or the sierra, or because their skin color is dark. Such people tend to remain quiet, keep off the streets, and stay hidden. They claim to often feel hopeless and frustrated, and their stance in life becomes passive.

Most Peruvians have been affected by the current situation to some extent. No group, culture, or social class has entirely escaped feeling the tension resulting from the violence and the economic concerns plaguing the country. According to a study by Peru's Association for Development, Education, and Integration, 80 percent of all Peruvians experience anguish, anxiety, and fear because of present conditions in their country.

SETTING CONGREGATIONAL PRIORITIES

Given the emotional characteristics candidates may bear when they enter formation programs in such a setting, as well as the characteristics of the society in which they aspire to work as church leaders, how may congregations best provide formation for their new members?

One of the first essential steps is for a congregation to ask itself, What are we training our members to do? What does Peruvian society most need now from the Catholic church?

Some congregations have identified the cultivation of mercy and reconciliation as their principal tasks in the current reality. As congregation members continue to insert themselves into the lives of the individuals they serve, they can easily see that they are among a people who hurt deeply. Mercy, therefore, is central. Congregations in Peru maintain that while they must recognize, define, and protest the violence, they must do so in the context of faith, with an eye continually on God's tender love.

In this society of conflict and violence, many desire to see church participation in the work of reconciliation. Such work would involve much more than encouraging people to pardon their oppressors; a process leading to true reconciliation would take years to complete.

MODELING CONSTRUCTIVE INTERACTION

How do we prepare people in formation for work within a mercy-bearing, reconciliation-focused church? Some congregations are centering their formation in a context of listening attentively to each person's story, maintaining a high degree of sensitivity to others, assuming responsibility for resolving one's own conflicts, and looking analytically at what is happening in daily life. In a nation whose history of class struggle still strongly colors current reality, where distrust and suspicion have almost become tactics for survival, such an approach carries many challenges.

The community life we create and invite candidates into must model such interaction. Through communication that allows people to express disagreements without losing their sense of identity, we model a positive way in which differing people can live together. We demonstrate alternatives to some of the negative or destructive aspects of life in Peru, such as the imposition of ideas and the oppression of all opposition and criticism.

FOSTERING A HEALING SPIRITUALITY

Congregations are recognizing that our new members need opportunities to share their feelings and to know they are not alone in experiencing them. One of the most critical feelings they need to express and learn to control is fear—an emotion that often exacts high physical and psychological costs. We need to share the fears that naturally arise in a violent society, especially those ignited by personal threats, by actual experiences with terrorism, or by doing something that could evoke a terrorist response (as in the aforementioned case of Alicia).

Religious communities in Peru are trying to model for new members a life-giving spirituality rooted in current social reality. Congregations are attempting to create spiritualities that lead them not only to announce the Good News but also to denounce life-threatening oppression. To do this, religious communities are looking to the history of Peru as well as to the history of our congregations' founders for inspiration in the struggle for justice and faithfulness to a vision.

Religious communities also struggle to foster spiritualities that conquer death. We try to help new members to view death in a healthy way and to recognize the possibility of their own death through service to the church in Peru. Death, we believe, must not cloud our vision of life, not even in the dark moments. We keep before us our witnesses to life, and we celebrate the hope given to us by Peru's many recent martyrs, including Irene McCormick (Sister of Saint Joseph of Australia, assassinated by SL in May 1991) and Maria Elena Moyano (33-year-old organizer of the poor, assassinated by SL in February 1992).

DEFENDING THE RIGHT TO DREAM

Perhaps most important of all, our programs of formation try to defend the right to dream. Despite all that has been denied to many of the Peruvian people, their right to dream remains. Hope for a new future and dreams of a just, peaceful society must be nurtured. Those dreams will sustain new members who are committing their lives to service so that poverty, suffering, and anxiety will not overshadow the future.

If Alicia's formation director searches for a clear, safe answer to give to Alicia regarding her youth group presentation, she will find none. Peru's situation is so tenuous that no one is ever sure which decisions may best foster mercy and reconciliation among those we serve. Alicia's director can, however, help Alicia look at her own history, identify more clearly her current fears, consider what the church is calling the congregation to do at present, and explore with Alicia the options for handling her situation. Then, perhaps, she can gently remind Alicia of her own dreams and, finally, allow Alicia to make her own decision. The process is hard and calls on both the director and Alicia to have tremendous trust in God's guidance and loving care.

Only with time and experience will religious congregations gradually see with more certainty how they can best collaborate with God to deal with challenging formation questions in times of crisis and violence. For those now living through such times, however, much depends simply on trust and faith.

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